Healthy Aging:
New Directions for Care

Part Three:
Implementing New Directions

November 1999

Long Term Care Review:
Final Report of the Policy Advisory Committee

Alberta
HEALTH AND WELLNESS

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This icon shows two hands reaching out in a gesture of support and caring. Not only does this gesture represent our concern for each other, but it also represents a handshake and therefore commitment. The white space between the hands forms an "H" in reference to the title of this publication, *Healthy Aging*.

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Addressing two challenges

Over the past two years, the Committee has learned a great deal from Albertans, from experts, and from looking at trends around the world. Many of those ideas were summarized in Part Two of our report – Listening and Learning.

Today, we face two major challenges in meeting the continuing care needs of Albertans.

The first challenge is to address immediate pressing needs. The Committee heard concerns about shortages of long term care beds to accommodate existing needs, a backlog of people waiting in acute care hospitals for admission to long term care centres, and the lack of sufficient home care services. These issues need to be addressed in the short term.

The second challenge is to plan for a very different continuing care system for the future – a system where more people are able to remain in their own homes and communities with the care they need, where supportive housing alternatives allow people to "age in place," and where services are well coordinated and accessible across the province.

Part Three of the Committee's report provides detailed recommendations for addressing both of those important challenges.

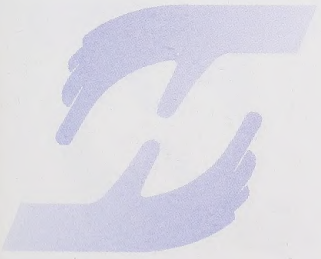
Addressing immediate issues

The health system today is under mounting pressure to meet the demands for continuing care services. There is a shortage of spaces in long term care centres. The waiting lists for continuing care are long and many people are waiting in expensive acute care beds. Home care resources are stretched, particularly as more people are being discharged early from hospitals and need care with their recovery at home. Currently, a number of spaces in long term care facilities are outdated and inadequate, with up to four people in a single room.

These issues need to be addressed. At the same time, the Committee believes that short term actions taken now should be consistent with a longer term vision of what we want to achieve in continuing care. There is no point in taking steps today, such as building a large supply of continuing care beds, if, in future, those beds are likely to stand empty as people choose other options, including staying in their own homes. What is needed is an effective bridge – short term solutions that address immediate problems but also support a longer term vision of new directions in continuing care.

"What is needed is an effective bridge – short term solutions that address immediate problems but also support a longer term vision of new directions in continuing care."

Policy Advisory Committee



Recommendation 1: Address immediate needs

The Committee recommends that:

- *Additional funding should be provided to address the current pressing needs in continuing care.*
  - *The first priority should be to increase support for home care services so that more people can receive the care they need at home rather than in facilities.*
  - *Steps should be taken to expand home care services in supportive housing arrangements such as expanding services available in lodges especially in rural communities, making use of subsidized apartments for seniors' housing, and expanding health services in coordination with home care.*
  - *Additional funding should be targeted to increase the number of qualified front line staff available to address the increasing acuity of people in long term care centres.*
  - *For people with complex and chronic health problems, additional funding should be provided to regional health authorities to allow them to look at all possibilities for using existing space and beds in the region, including re-opening closed beds. Although these beds are located primarily in acute care centres, they could be used on a short term basis to accommodate people with higher health needs. There should be minimal disruption to people who are already living in long term care centres.*
  - *For people with less serious health problems, the priority should be on expanding home and community care, providing respite care for informal caregivers, and expanding supportive living arrangements.*

Comments:

In the short term, additional funding is needed to address current pressures in continuing care. The Committee does not have sufficient information to recommend specific targets for additional funding to meet immediate needs. We suggest that regional health authorities be asked to identify the immediate needs in their region. We also recommend that additional funding should be targeted to meet the most pressing needs in the province, rather than providing an across the board increase in funding for all regional health authorities.

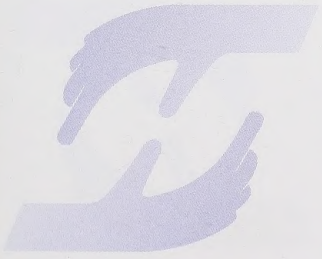
In the longer term, the Committee envisions a continuing care system where fewer people will need care in long term care centres. More people will be able to remain in their homes or in supportive living arrangements while long term care centres will serve only people with complex and chronic health needs. While the Committee recommends that additional spaces will be required over the next five years, we urge caution in "over-building" long term care facilities if people's needs can better be met in other, more appropriate and less costly alternatives.

For that reason, the Committee suggests that the first priority should be to expand home care services and ensure that those additional resources are used to meet the needs of people with long term home care needs. Steps also should be taken to increase the availability of home care services in supportive housing arrangements. The second priority should be to increase the number of qualified front line staff available to work in long term care centres.

At the same time, the Committee understands that there is a backlog of people who need to be cared for in long term care centres. Finding more appropriate spaces to care for these people would free up acute care beds in hospitals for people who have acute illnesses. In addition, acute care beds are not an appropriate environment for people with long term health care needs.

"... there needs to be a province-wide capital project strategy which recognizes the ongoing needs for upgrading, replacement and development of a number of models for facility-based continuing care."

From public consultations



Therefore, the Committee recommends that every effort be made to make use of existing spaces and beds. This may mean re-opening wings in hospitals or re-opening beds that have been closed for financial reasons. As a bridging and interim strategy, the existing spaces could be converted to continuing care beds on a short term basis. The cost would be less than building new spaces. And it would provide an immediate solution, whereas building new spaces will take time.

Over the next three years, the Committee suggests that plans be in place to open an additional 600 beds in long term care centres to accommodate projected needs. However, these additional beds will take time to build and will not be sufficient to meet the current needs unless immediate steps are also taken to expand home care services and supportive living arrangements.

Setting a new direction

With an aging and changing population, it is important to look ahead – to decide what the vision for continuing care should be and what steps should be taken to turn that vision into reality. It involves asking questions like these: Is the current system adequate to meet people's needs and expectations? Are there better ways of providing services? Are the current approaches consistent with what people will want and need in the future?

In answering those questions, the Committee believes that a fundamental change is needed in continuing care in order to improve services and meet the needs and expectations of a new generation of older Albertans.

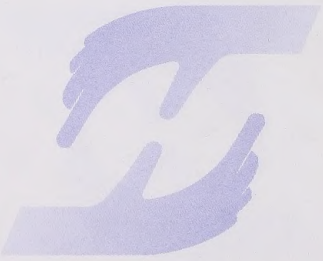
A new vision of aging in the 21st century

Our vision for aging in the 21st century is a society where all Albertans:

- *Are treated with respect and dignity*
- *Have access to information which allows them to make responsible choices regarding their health and well-being*
- *Can achieve quality living, supported as needed by relatives, friends and community networks, and by responsive services and settings.*

"We would do better to ask where we want to go and to work out policies and strategies to lead us there."

Dr. Satya Brink, Special Advisor, Human Resources Development Canada



"Older persons and those with disabilities are individuals with desires and dreams to lead rich and fulfilling lives in all dimensions of their being – physical, emotional, mental, social, intellectual and spiritual."

From public consultations

Guiding principles

Consistent with the vision, the following guiding principles will help the health system respond to an aging population.

Wellness and prevention

- Support healthy aging for all Albertans.
- Emphasize promotion of health and prevention of illness, injury and disease.
- Help Albertans to cope effectively with chronic conditions and function to the best of their abilities.

Client centered

- Endeavor to understand and meet client and family needs, work in partnership with clients, and ensure client choice where possible.
- Acknowledge the client's right to dignity and self-determination.
- Have reasonable access to a variety of affordable services and have their needs met in a flexible, timely and responsive manner.
- Respect the client's right to privacy of space and person.
- Recognize and respond to the physical, psychological, spiritual and social aspects of health.

Information

- Provide clients with access to information required to make informed choices and decisions regarding care and services.
- Ensure confidentiality of personal information, however, allow appropriate sharing of information to support the highest quality of services and best possible outcomes.

Individual and shared responsibility

- Encourage independence by assisting Albertans to reach their greatest potential, recognizing that clients and families have the primary responsibility for their own health.
- Recognize the concept of interdependence and facilitate collaboration between Albertans, community and government.

Effectiveness and efficiency

- Make decisions based, as much as possible, on the values of the consumer, on evidence provided through research, evaluation and technology assessment, and available resources.

Intersectoral approach

- Recognize that, by working together, Albertans, government, regional and provincial authorities, non-government organizations, and the voluntary and private sectors all have an active role in contributing to the health of Albertans.

"Aging is not a disease to be treated but a state of living and being."

Alberta Association of Registered Nurses

"The direction will be very different from today. It will reflect a fundamental shift, putting the needs of the individual first and giving people choices in where and how their assessed needs are met."

Policy Advisory Committee

What will continuing care be like in the future?

The direction will be very different from today. It will reflect a fundamental shift, putting the needs of the individual first and giving people choices in where and how their assessed needs are met.

In the 21st century, the Committee envisions a continuing care system with the following defining features.

▸ People have choices

Most people choose to remain in their own homes and communities and be able to choose among a range of services tailored to meet their needs. Institutional care is be the exception, with a new generation of facilities serving only people with complex, chronic health needs, people whose needs can't be met in the home or community.

▸ Healthy aging

There's a life-long focus on staying healthy and well, and healthy aging becomes the watchword for Albertans. Education, promotion and prevention programs begin with children and continue right through to targeted strategies for older Albertans.

▸ People first

The person comes first. A variety of services are available to meet people's needs and the emphasis is on "bringing service to the people" instead of "bringing people to the service."

▸ Better access

There is coordinated access to all types of continuing care and better coordination of services among home care, supportive housing, and continuing care centres. The system includes a broader range of options and there are close links with other services such as transportation and a variety of programs provided by volunteer agencies.

▸ Integrated care

New primary health care models for the elderly provide well coordinated and integrated health services, particularly for the frail elderly and people with chronic health conditions. Family physicians, geriatricians, registered nurses, social workers, physical and occupational therapists and other professionals work together with individuals and their families to assess and meet the needs of Alberta's seniors.

▸ Aging in place

At home

Home is where the majority of services are provided and the other options are substitutes for getting the care people need at home. The vast majority of seniors remain in their own homes as long as possible with the care and support they need, when they need it. Home care and community programs are expanded.

In supportive housing

Options for supportive living continue to grow and provide seniors with a wide range of alternatives and different types of care to meet their needs. Services are "unbundled" from the type of housing so that people can make choices and tailor services to meet their assessed needs. These new options are available in communities across the province and allow Albertans to "age in place."

▸ A new generation of continuing care centres

With most people staying in their own homes or choosing supportive living arrangements, continuing care centres serve only those who have high health needs. The facilities are improved, creating a new generation of innovative designs and ways of delivering services. There are close links with both acute care settings and community, and home care. Continuing care centres are sites for facility-based long term care as well as palliative care, sub-acute care, respite care, care for people with Alzheimer's disease and other dementias, wellness and community care programs, and programs for people of all ages who have continuing care needs.

"The stakes are high if greater integration of health care delivery is not achieved. In the absence of integrated management, there is no incentive to ensure the transitions or bypasses from institutions to community care are in place."

Laurie Thompson, Saskatchewan Health Services Utilization Research Commission

▸ Special services for special needs

Specialized services are available for people with Alzheimer's disease and other dementias, for those with mental illnesses, for frail elderly people with complex needs, and for people of all ages with specialized longer term health needs. Programs and services are sensitive to the needs of disabled Albertans.

▸ Support for informal caregivers

Respite programs are available to support informal caregivers. Their role and contributions in caring for family members and friends are recognized and supported. Informal caregivers are considered part of a team of people working together to meet an individual's needs.

▸ Highly skilled providers

More people – physicians, nurses, other professionals and support staff – have the understanding, skills, expertise and training to work with an aging population. Technology and other new approaches provide opportunities for health professionals to upgrade their skills and keep pace with the latest ideas and approaches.

▸ Leading the country

Alberta leads the country in teaching, research, and innovation in delivering services to an aging population.

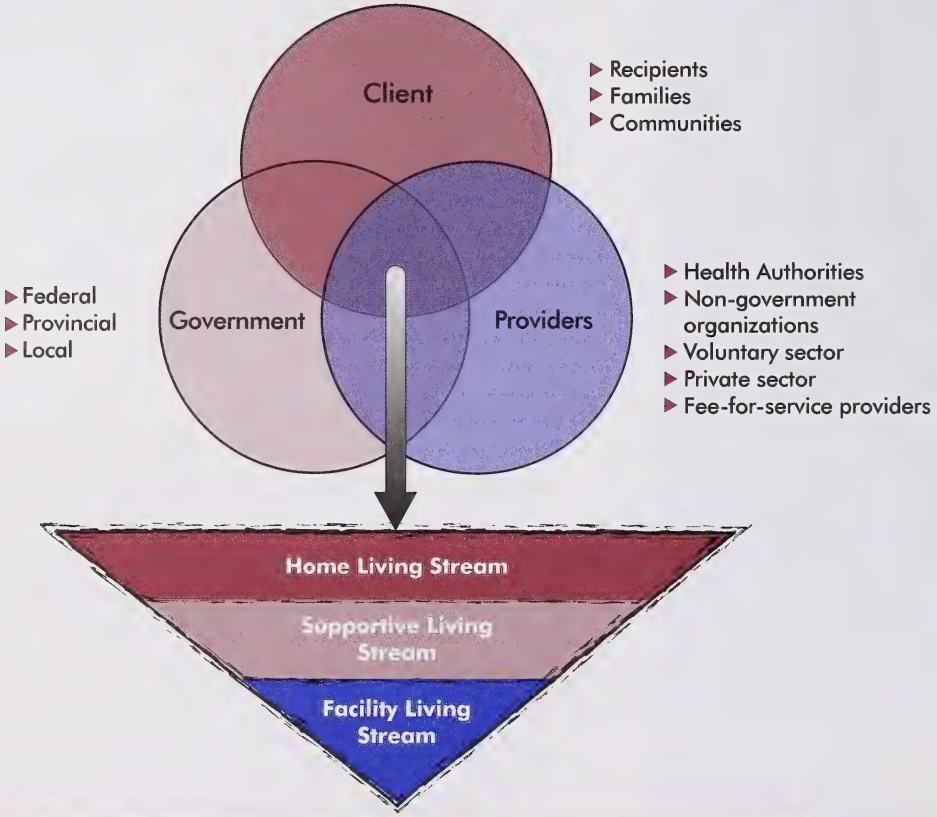
That is a snapshot of the kind of continuing care system we envision for Alberta in the 21st century. The following sections provide more information on the types of services and changes that would be required to make that vision a reality.

Figure 1

Vision of Aging for Albertans in the 21st Century

Our vision of aging in the 21st century is a society where Albertans:

- Are treated with respect and dignity.
- Have access to information which allows them to make responsible choices regarding their health and well-being.
- Can achieve quality living, supported as needed by relatives, friends and community networks, and by responsive servies and settings



Source: Alberta Health. Policy Advisory Committee. Long Term Care Review. 1998.

"... successful aging is largely determined not by genetic inheritance – as common wisdom has it – but by individual lifestyle choices in diet, exercise, the pursuit of mental challenges, self efficacy, and involvement with other people."

Dr. John W. Rowe and Dr. Robert L. Kahn, Successful Aging

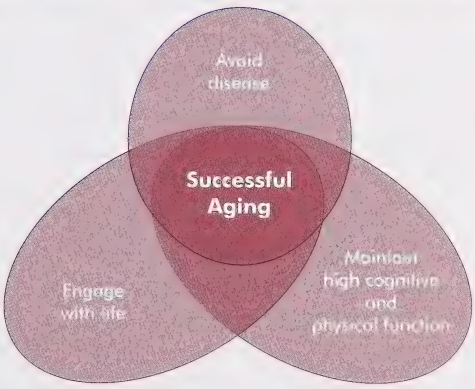
Healthy aging – it's up to all of us

Healthy aging begins from birth, with a healthy childhood and active steps to maintain good health throughout our lives. But too often, we give up too soon on healthy aging strategies for seniors, thinking that it's either too late to make a difference or that lifestyle changes can't make up for a genetic predisposition to illness or early death.

In fact, recent studies show that changes in lifestyle – whether that involves quitting smoking, improving diet, exercising more or making other changes – can make a positive difference no matter how late in life they are made. Over 50 rigorous research studies have demonstrated that programs for seniors aimed at preventing diseases and promoting good health reduced their use of health services and improved their functional level, health status and quality of life.

Figure 2

The Structure of Successful Aging



Source: *Successful Aging*, by Dr. John W. Rowe and Dr. Robert L.Kahn

That is not to suggest that all diseases can be prevented through adopting a healthy lifestyle. Good health and healthy aging certainly depend on a number of factors. According to *Successful Aging* by Dr. J. W. Rowe and Dr. Robert L. Kahn, a recent report from the MacArthur Foundation Study of Aging

in America suggests that healthy aging is determined by a combination of three factors: avoiding disease and disease-related disability, maintaining high mental and physical function, and being actively engaged in life.

The Committee recognizes that individuals have the primary responsibility for making choices and maintaining their own health. At the same time, there are things that can be done to support and inform people about the choices they can make. Programs to promote good health and prevent illness and injury are important for all ages, including seniors. For seniors, strategies should be focused on preventing falls, injuries and illness; promoting self care, good nutrition and exercise; and providing social and community support, and adequate housing.

While many seniors want to remain independent as long as possible, this sense of "independence" has to be balanced with "interdependence" – the importance of getting and accepting help when people need it without losing their independence. This concept of "interdependence" means that people should be able to rely on others – family members, friends, the health system, and others – to provide support when it is needed.

Many of the factors necessary to ensure healthy aging go well beyond the health system. They relate to education, employment, housing and income support. Through its review, the Committee heard that the whole concept of retirement and retirement age should be re-thought to match the improved health status and increasing life expectancy of Albertans. Policies relating to retirement age and working conditions need to be reconsidered to promote more active involvement of seniors. Education programs should assist the new wave of seniors to prepare for a lengthy retirement. The Committee suggests that these issues should be considered by the Government-Wide Study on the Impact of the Aging Population currently underway in the province.

In addition, there is a need for ongoing education and research to track trends in the health of older people and uncover new ideas about healthy aging. Specific recommendations about education and research are included in later sections of this report.

Recommendation 2: Promote healthy lifestyles and prevent illness and injury

The Committee recommends that:

- *Policies and programs to support healthy aging should be a priority for the provincial government. There should be an initial investment across government and sufficient resources – funding, people, commitment and knowledge – should be available to support the implementation and delivery of healthy aging programs and services.*

- *Alberta Health and Wellness and regional health authorities should work with seniors, physicians, volunteer agencies, government departments and other stakeholder groups to develop health policies and strategies to support healthy aging.*

- *Higher priority should be placed on programs that promote healthy lifestyles and prevent illness and injury including good nutrition, active living, immunization, eliminating smoking, preventing falls, and preventing illnesses that can lead to chronic health problems.*

- *Regional health authorities should have an expanded capacity to provide health promotion and prevention programs targeted at healthy aging. As part of their business plans, regional health authorities should be required to have a specific plan to develop, implement, measure, monitor, and evaluate progress in implementing healthy aging strategies.*

- *Regional health authorities should develop strategies to identify elderly people at risk. This could include case finding and screening processes, and other actions designed to identify health needs in elderly people and take steps to prevent further deterioration of their health.*

Comments:

There is a growing recognition that programs to promote good health and prevent illness and injury are an essential component of our health system. Across the province, healthy lifestyles are being promoted by regional health authorities, physicians, nurses, corporations, volunteer and community groups, and universities. New approaches to primary health care are also putting more of an emphasis on promoting healthy lifestyles.

But in face of other priorities, especially in acute care, these programs have often received lower priority. The Committee feels that government should adopt healthy aging as a priority for action and devote the necessary resources to ensure that effective programs are in place.

A key message is that it's never too late to take steps to promote healthy aging among seniors. The Committee recommends that a higher priority should be placed on providing programs targeted at an aging population to promote healthy lifestyles and prevent many of the chronic health conditions and diseases that affect seniors.

"It's never too late to take steps to promote healthy aging among seniors."

Policy Advisory Committee

"Affordable, healthy, active living should be promoted and incorporated into the daily lives of all persons, regardless of abilities, disabilities, age, gender or financial circumstances."

From public consultations

"Health professionals need more extensive education in heath promotion pertaining to seniors, in empowering interventions, in partnership relationships with seniors that enhance knowledge and status, and in promoting self-care practices."

Dr. Miriam Stewart, Director, Centre for Health Promotion Studies, University of Alberta

"Not surprisingly, when asked their 'secret' to aging well, many of the 'successful agers' from the MacArthur Study echo the same refrain: 'Just keep on going'. It is this forward-looking, active engagement with life and with other human beings that is so critical to growing old well."

Dr. John W. Rowe and Dr. Robert L. Kahn, Successful Aging

"Within the shift toward a more appropriate health care system, there must be support and resources for empowering citizens. The educational process emerges as key to this strategy."

Dr. Neena Chappell, Director, Centre of Aging, University of Victoria

Recommendation 3: Empower and engage seniors

The Committee recommends that:

- *Strategies should be implemented to assist elderly people to cope with chronic conditions, maintain their independence and ability to manage their own care, and improve their quality of life. Alberta Health and Wellness should take the lead to work with regional health authorities, seniors, and other agencies to develop and implement these strategies.*

- *Strategies should be developed to promote active engagement in life for older persons. These strategies should be developed jointly by Alberta Health and Wellness, health authorities, physicians, seniors, other government departments, voluntary and community agencies.*

Comments:

Maintaining active involvement and participation in life and taking steps to maintain mental health are essential components of healthy aging.

The Committee feels that more can be done to recognize seniors and expand their ability to stay involved and active in the community. Examples include workshops to help seniors deal with chronic diseases, volunteer outreach programs, library access and information on the Internet.

Specific engagement strategies could include expanding recreational and social activities for elderly persons, developing social support networks and supports to strengthen communities, and fostering dialogue across generations to build better understanding and support for an aging population.

The Committee also wants to see specific attention paid to the mental health needs of an aging population. Currently, there is very little emphasis on mental health issues for the elderly, in spite of the fact that dementia is often quite common in older people. Specific recommendations on this issue are included in later sections of this report.

Recommendation 4:
Design future communities for an aging population

The Committee recommends that:

- *Alberta Health and Wellness should work in partnership with the different levels of government, the housing industry and corporate sponsors to design future communities where seniors can "age in place," retain supportive networks of family and friends, and experience a positive quality of life.*

Comments:

Later in this report, we make recommendations about the different streams of living for an aging population. We recognize that where people live and their ability to maintain contacts with family and friends and access services are all a part of healthy aging. In future, the Committee would like to see communities that combine care and housing, incorporate living and working environments, and create places that are more "senior friendly" and "disabled friendly." Special attention should be paid to conveniences such as having shopping centres and community health centres nearby, providing both inside and outside recreational facilities, and providing access to transportation.

Objectives for the International Year of Older Persons point to the need to increase recognition of seniors' contributions to their families, their communities and the country.

"... society tends to have negative attitudes towards aging. Health care providers are not immune from this form of thinking. Often times, health providers (and especially acute health care providers) are quick to say, 'you're aging' when there is a complaint by an older patient; to prescribe something for the older person to calm them; or to believe that after a certain age you can't expect to remain independent. This mindset needs to change."

From public consultations

Providing quality services for an aging population

Combined with strategies to promote healthy aging, it is important that Alberta's future continuing care system provide the services people need, when they need them, and in the most appropriate setting. The following sections outline changes that should be made in:

- Providing primary health care for the elderly
- Improving the delivery of acute care services
- Setting a new direction for continuing care services
- Providing coordinated access to a full range of continuing care services
- Setting new directions for three living streams.

Providing primary health care for older people

In the current health system, family physicians, specialists, nurses and other health providers are working hard to address people's health care needs. However, the system needs to be better organized to meet the needs of older people, particularly those with complex health needs. Responsibilities for coordinating the care for these people are not clear. There is a complex system of referrals and duplication in assessment and laboratory and diagnostic tests. The current payment and funding systems discourage preventive care and the comprehensive approach needed when dealing with the frail elderly. Further, all to often a frail individual with ongoing care needs is unable to develop lasting relationships with health care providers, simply because the provider changes from day to day.

We know what we want and need. We need:

- An integrated and coordinated approach – where services are organized around the complex needs of older people (e.g. PACE and CHOICE programs), a particular type of illness (e.g. Alzheimer's disease, heart conditions, or other illnesses), or a particular need such as pain management.
- Continuity of care including physicians' services, home and community care, acute care, and care in long term care centres
- A clear link between health care and other community services
- Consistent relationships between individuals and health care providers, especially within home care
- A multidisciplinary team approach to meet the needs of frail older people
- Increased involvement of individuals and communities in planning and developing programs
- Services based on evidence that they provide the health outcomes we want and expect
- Funding approaches with the right incentives to provide coordinated care for the elderly.

To achieve those objectives, the Committee's view is that a primary health care model is needed. Primary health care is care that is provided at the first level of contact with the health system – where people first enter the health system and where services are mobilized and coordinated to promote health, prevent illness, care for common illness and manage health problems. It is a comprehensive approach that addresses not only illness and injury, but also prevention programs, promotion of good health, and strategies to improve the health of the population.

Primary health care services include screening, health information, eye exams, physical examinations, treatments in the physician's office, vaccinations, hearing exams, home visits, nutritional counselling, some mental health services, drug dispensing and information, and palliative care. Primary health care providers include not only family physicians,

"The care of seniors is considered primary health care and should be delivered at the community level wherever possible. While some seniors may require highly specialized geriatric care and/or institutional care, the vast majority of senior patients will – and should – seek their care through primary, community-based sources."

Alberta Medical Association

"There is an opportunity in Alberta to be innovative and look at new models of service delivery such as community health centres and collaborative partnerships where physicians and registered nurses work together with other health care providers to provide services to the public."

Alberta Association of Registered Nurses

registered nurses, public health nurses and nurse practitioners, but also other health professionals and community workers. A number of primary health care pilot projects are currently underway in health authorities across the province.

For older people, especially the frail elderly, an ideal primary health care model would:

- Provide comprehensive, well coordinated care for older people with chronic and complex health problems
- Identify people with chronic and complex illnesses
- Provide systems for monitoring their health
- Provide targeted health promotion and disease prevention activities
- Educate patients on self and family care
- Assist with the appropriate use of medications
- Coordinate and integrate care
- Provide a combination of medicine, nursing, social work, rehabilitation and support services
- Provide a quick response if the patient destabilizes.

Recommendation 5: Adopt a primary health care model for services to older people

The Committee recommends that:

- *A primary health care model should be adopted as the most effective approach for providing health services to older people with complex health care needs. An example would be expanding integrated care delivery programs such as PACE and CHOICE programs.*

- *A five-year strategic plan and implementation strategy should be developed to expand primary health care models across the province with a priority on meeting the needs of frail elderly people with complex, chronic health care needs.*
  - *Part of the action plan should include a review of how programs and services are currently funded to ensure that there are appropriate incentives for taking a primary health care approach to services for older people.*

- *Alberta Health and Wellness should work with health authorities, physicians, registered nurses and other health providers, the voluntary and private sectors, and agencies to develop a provincial framework and prototypes for primary health care for older people.*

Comments:

While a number of primary health care pilot projects are underway across the province, the province needs to take the lead in developing a specific action plan to expand primary health care models across the province with priority on meeting the needs of frail elderly people with complex, chronic health care needs.

"In a truly patient-centred approach to health care, in which patients are active, willing partners in their health, physicians should be compensated for the time they invest in educating and counselling patients about healthy living and the range of health care options ... The Alberta Medical Association has taken a lead role, working with Alberta Health and regional health authorities, in researching flexible and innovative options within physician remuneration."

Alberta Medical Association

Recommendation 6: Coordinate health services for older people within and between regions

The Committee recommends that:

- *Health authorities should develop and implement strategies to coordinate care for elderly patients with multiple health needs and ensure that services are integrated within their region and coordinated with other regions. This will, of necessity, mean that providers of primary health care (physicians, nurses, and others) need to work together dynamically as teams.*

Comments:

Health authorities are responsible for delivering services and coordinating care for people in their region. The Committee understands that many regions have taken active steps to manage and coordinate care for elderly people. This should be a priority for every region in the province.

Improving delivery of acute care services

Today, most Albertans enjoy healthy and productive lives well into their older years. Too often, we equate aging with increasing illness and disability. In fact, the majority of Alberta's older people are healthy and lead active lives.

At the same time, as people age, the likelihood of them needing health care services in their homes, their community or in a hospital increases. And while it's not fair or accurate to suggest that aging alone will put increasing pressures on the health care system, the reality is that almost 45% of patient days in acute care hospitals are used by people over 65 years. By 2031, about one quarter of Alberta's population will be over 65. We need to start planning now to ensure that our acute care hospitals are well prepared and well organized to meet the needs of an aging population.

Combined with increasing demands for health care, there also are problems with the way acute care services for the elderly are organized and delivered today. Family physicians, nurses and other health providers play a vitally important role in identifying and responding to older people's health needs. However, as noted in earlier sections of this report, acute care hospitals and medical services were developed when people's average lifespan was shorter and their medical needs were less complex.

Typically, acute care hospitals and medical services are organized to deal with a specific medical diagnosis rather than the complex, multiple problems and chronic conditions of the elderly, particularly the frail elderly. The result is that, too frequently, frail elderly people go to emergency departments for treatment. They are treated by physicians and health providers who have excellent diagnostic skills for illnesses but often are not trained to deal with the multiple conditions of the frail elderly. They are diagnosed, often have long stays in hospital, then are discharged without a coordinated plan in place for follow up care. Within a short time, they're back in hospital again.

"Unfortunately, we have trained generations of doctors and other health care professionals without teaching them that in frail old people, [all] bets are off. When frail old people get sick, they usually simply get confused, or they fall, or they take to their bed and won't get out."

Dr. Ken Rockwood, Professor of Medicine, Dalhousie University

In Alberta, we need to reorganize acute care and acute geriatric services so that:

- Delivery of acute care to older people is well organized and able to meet increasing demands
- Strategies are in place to identify people who are at risk and to address the complex health problems of elderly people, both in communities and in facilities
- Care for the elderly is integrated and well coordinated to ensure that there is continuity across the different types of health services
- A primary health care approach is taken, combining medical treatments with social and other supports provided by a multidisciplinary team of health professionals and others
- The vitally important role of family physicians, specialists, nurses and a range of health care providers is recognized and supported
- Comprehensive geriatric assessment becomes the minimum standard in addressing the complex chronic needs of the frail older person with an acute illness
- Geriatric assessment services are enhanced across the province, particularly in rural communities
- Specialized geriatric training is available for physicians, nurse practitioners and other hospital staff who work with elderly people
- Quick Response Teams and drop in clinics for seniors at risk are in place and long term care centres are able to provide some acute care services. These steps help prevent unnecessary admissions to acute care hospitals and ensure that home care plays a key role in admission of people to hospital
- Discharge plans are in place for all people
- Health authorities have adequate resources to provide acute care for elderly patients and are accountable for the services they provide.

Recommendation 7:
Re-organize acute care services

The Committee recommends that:

- *Medical and acute care services and practices should be reorganized so they are better able to meet the needs of an aging population, the frail elderly, and older people with chronic health conditions.*

- *Alberta Health and Wellness should take the lead in working with regional health authorities, physicians, health providers, university-based educators, seniors and stakeholders to develop a provincial framework for organizing and integrating acute care services to meet the needs and increased volume of elderly people. This would include establishing the standards, expectations and outcomes for acute geriatric care in the province. It also should clarify the roles and responsibilities of acute care, home care, long term care centres, community care, mental health, and the role of regional health authorities.*

Comments:

Currently, medical and acute care services are not well organized to respond to an aging population and to meet the complex needs of elderly people. Alberta Health and Wellness should take the lead to work with health authorities, physicians, geriatricians, nurses, academics, health providers – and seniors themselves – to develop the most effective ways of organizing the acute care system to meet the needs of elderly people. The framework must account for the high prevalence of chronic illness, cognitive impairment and functional decline in our elderly population.

"Despite the energetic efforts of the teams [of health care providers] the care of the elderly both in the community and in our health care facilities is far from ideal. For the frail seniors living in their homes, access to health care appropriate to their needs is not an easy matter. The activities of primary care physicians located in their offices or clinics and the ongoing function of home care workers interacting with frail, disabled and demented elderly to a large extent 'pass like ships in the night'."

Dr. Peter N. McCracken,
Past Divisional Director,
Geriatric Medicine,
University of Alberta

"In the future, there will be little difference between acute care and acute geriatric care. Almost all acute care will be geriatric care."

Dr. Peter McCracken, Past Divisional Director, Geriatric Medicine, University of Alberta

Recommendation 8: Expand acute geriatric services in the regions

The Committee recommends that:

- *Regional health authorities should be responsible for working with people in their region to assess acute geriatric services, deliver programs and services consistent with the overall provincial direction, and monitor and evaluate the effectiveness of the services they provide.*
- *Regional health authorities should develop strategies to prevent unnecessary admissions of elderly people to acute care hospitals.*
- *Clear alternatives to emergency room care and traditional in-hospital care should be available for frail elderly people who develop acute illnesses. Staff in emergency rooms and in acute care hospitals should have processes in place to identify "at risk" seniors.*

Comments:

Regional health authorities, together with physicians and other health care providers, are in the best position to understand the geriatric acute care needs in their community, to develop appropriate programs and services, and to assess the effectiveness of the services they provide. Many regional health authorities already have taken steps to provide better coordinated care for elderly people.

Steps need to be taken to prevent unnecessary admissions to hospitals when other alternatives are preferable. Examples include:

- providing specialized multi-disciplinary clinics for seniors at acute risk in the community
- developing Quick Response Teams who are used to addressing the health problems of frail elderly people
- ensuring that people in emergency rooms and other acute care settings are ready, willing and able to identify "at risk" seniors
- expanding the ability of long term care centres to address certain episodes of acute illnesses without having to transfer people to hospitals
- involving home care staff and primary physicians in admission decisions
- involving community health nurses and home care workers in geriatric surveillance programs to identify elderly people at risk of more serious health problems.

Steps need to be taken to prevent further cognitive and functional decline for frail older people who are admitted to hospital with ongoing acute illnesses. Examples include expanding availability of Geriatric Assessment Teams (GAT) either directly or by telehealth and expanding access to Acute Care of the Elderly (ACE) units.

Steps also should be taken to provide intensive rehabilitation services that bridge acute care hospitals and community care and prevent long stays in hospital. Transitional services should be in place for people whose needs are not serious enough to require hospitalization but are too serious to be dealt with in the community. This includes options like sub-acute beds currently being developed by many regional health authorities and long term care centres.

To help support acute care providers in the management of older patients, it is recommended that we:

• Establish hospital medical/surgical units designed to improve the standard care provided to seniors ... often called Acute Care for Elders or ACE units ...

• Establish hospital-based Geriatric Consultation Teams/Geriatric Assessment and Intervention Teams to assist physicians and staff in the care of older patients ...

- *Implement strategies to identify the hospitalized senior at risk for functional decline ...*
- *Develop strategies to improve ER care and prevent avoidable admissions..."*

Dr. David Hogan,
Professor, Faculty of Medicine,
University of Calgary

Recommendation 9: Expand geriatric assessment services across the province

The Committee recommends that:

- *Geriatric assessment services should be available in all regions across the province.*
- *Alberta Health and Wellness should review how geriatric assessment services currently are provided across the province and determine whether or not geriatric services should be considered as a provincial program.*
- *Expanded educational programs should be available to provide specialized geriatric training for physicians, nurse specialists, and other staff of acute care hospitals.*

Comments:

Currently, geriatric assessment services are available primarily in urban centres and very little capability exists in rural communities. Alberta Health and Wellness should work with health authorities to expand geriatric assessment services to every region of the province. This could be done through expanding access to Geriatric Assessment Teams (GAT) - multi-disciplinary teams with geriatricians providing consultation services to family physicians and primary health care workers. To ensure that there are adequate resources available to meet this need, Alberta Health and Wellness should review whether geriatric services should be provided as a province-wide service. This issue also is addressed as part of recommendations on funding methodologies.

The Committee also consistently heard about the need for expanded training for physicians and other health providers to assist them in assessing, diagnosing and responding to the needs of elderly people. A specific section on training and education is included later in this report.

Recommendation 10: Strengthen case coordination and improve discharge planning

The Committee recommends that:

- *Provincial protocols for case coordination and discharge planning should be developed and implemented not only within hospitals but also between hospitals and other programs and services within and outside the region. Alberta Health and Wellness should take the lead to work with regional health authorities, physicians and health providers to develop these protocols.*

- *Every regional health authority should have effective processes for discharge planning in place to ensure appropriate coordination and support for self care or family care, and access to continuing care services in the region and between regions. These discharge planning processes are especially important when home care is not involved and individuals and their families are responsible for follow-up.*

Comments:

Appropriate discharge planning is essential to ensure there are clear links between services provided in hospitals, in communities and in the home.

The critical element in linking hospital and community services is a coordinator who is familiar with the hospital and hospital units, and who can command and coordinate the range and amount of services individual patients require. In most cases, these coordinators are employed by home care programs and work consistently in specific hospitals and in specific units. They get to know the nurse managers and other key individuals involved in discharge planning.

"Discharge planning is complex, multidimensional, transprofessional, fraught with ethical dilemmas and communication difficulties, difficult to execute well, and experienced as out-of-their-control, confusing and anxiety provoking by patients and their families. When everything that can go wrong and frequently does is taken into account in discharge planning, one is left to marvel that any patient ever leaves a hospital and ends up in the most appropriate place for him with any of the services he needs. Remarkably, that does happen."

Dr. Dorothy Pringle,
Dean of the Faculty of Nursing,
University of Toronto

While these hospital-based coordinators provide a critical link, they are not discharge planners. They are part of a discharge planning team, working together to arrange the services patients need when they are discharged. When there is sufficient flexibility and good discharge plans in place, there is a smooth transition from the acute care hospital to other services in the home and community, and there is less stress on the patient, on families, and on health providers.

Discharge planning should be considered an integral part of the health care delivery system. It provides effective linkages between hospitals and community services, and it helps ensure the most effective use the resources available.

Setting a new direction for continuing care services

In earlier sections of this report, we proposed a new vision and described what health care services should look like in the future if the vision and the recommendations of the Committee are implemented. Key elements include a higher priority on healthy aging, a new way of organizing and delivering acute geriatric services, and a new focus on primary health care.

It's also important to look at the full range of continuing care services provided today and consider how those services can be better coordinated and delivered to meet the needs of an aging population. Part Two of the Committee's report described potential scenarios for the future and the scenarios preferred by some Albertans.

Looking ahead, the Committee has set a vision where:

- The majority of older people will continue to live in their own homes as long as possible, with the care and support they need provided in their homes and in the community.
- People will have choices in where they live and the kinds of services they receive.
- Expanded opportunities for supportive housing will be available in communities across the province.
- Continuing care services will be brought to the person instead of bringing the person to the services.
- Continuing care centres will serve a lower proportion of the population but will provide high quality specialized care and support for elderly people with complex and serious health needs. These centres will also be providing various services, including sub-acute care, respite care, day programs, and programs for people with Alzheimer's disease and other dementias.

Consistent with that vision, the following recommendations outline the Committee's views on the best future scenario for Alberta.

"Declining our institutional rate of elderly would not, in my view, constitute a crisis, provided alternate forms of care are pursued actively. The advent of many alternative approaches to care renders the bed target of the past a less dependable measure."

Phil Gaudet, President, Canadian Home Care Association

Recommendation 11: Adopt a new scenario for the future of continuing care

The Committee recommends that:

- *Continuing care services should be delivered in three streams – the home living stream, the supportive living stream and the facility-based stream.*
  - *The first priority should be to keep elderly people in their homes as long as possible.*
  - *By 2005, there should be a moderate shift from the current situation. A smaller percentage of the population should need to be served in continuing care facilities and there should be a corresponding increase in alternative supportive housing arrangements and care in the home. By 2016, there should be a major change with more supportive living options, expanded care in the home and a corresponding reduction in the proportion of people needing continuing care facility beds.*
- *Alberta Health and Wellness should develop a five year implementation plan to achieve the targets set in the scenarios and to implement strategies to:*
  - *"unbundle" health care services, support and housing services, allow flexibility in packaging services to meet an individual's needs, and review subsidy policies to reflect these new approaches*
  - *expand community and home care services*
  - *expand supportive housing and care sites*
  - *upgrade continuing care centres to care for elderly people with more serious and complex health needs*
  - *develop a new generation of continuing care centres with new and innovative designs and methods for delivering services.*
- *The future scenarios and progress in implementing those scenarios should be reviewed at least every three years.*

Comments:

Extensive work was done by the study *Future Scenarios: Continuing Care Service Needs in Alberta* to develop alternative scenarios and to forecast future volumes of service in each of the three streams for each of the four scenarios. A summary of the four scenarios was provided in Part Two of this report. Complete details are available in the Future Scenarios report.

The Committee believes that, by 2005, it is possible to achieve a moderate shift with a smaller proportion of people living in continuing care centres and a corresponding increase in the number of people who are able to remain in their own homes or in supportive living arrangements. This reflects Scenario 2 developed in the *Future Scenarios: Continuing Care Service Needs in Alberta* study. It reflects the preference for the vast majority of seniors to remain in their own homes as long as possible. But it also takes into account the need to develop additional supportive housing developments across the province and expand home care services.

In the longer term, by 2016, the Committee envisions a major change from today's situation (Scenario 3) with an actual reduction in the *proportion* of people using long term care centre beds in the province combined with a significant increase in supportive housing units and home care services.

While the proportion of people living in long term care centres is expected to decline in the longer term, there is an immediate need for increases in the number of beds available. Considering the current projections and the backlog of spaces available for people who need continuing care in facilities, the Committee suggests that an additional 600 beds will be needed over the next three years. Combined with new beds, steps are needed to expand home care services and increase supportive housing options in order to meet immediate needs.

It is important that services be "unbundled" in order to provide choice and flexibility in meeting the changing needs

"Unbundling housing and personal care from health facilities while promoting unique combinations of housing and care, I believe, is our most powerful paradigm shift for designing future care opportunities."

Nancy Gnaedinger, Consultant in Gerontology, Victoria, B.C.

"In the past, there were only two options for older people with health problems – stay in hospital or move to a long term care centre. In the future, staying at home or in flexible supportive housing arrangements will be the first option. People will only need to move to a long term care centre when their health needs can no longer be met at home. And hospitals will be only used when people are acutely ill."

Policy Advisory Committee

of an aging population. Currently, services are bundled together, people have limited choices, and they are expected to pay a portion of the costs of the package of services. If the services are "unbundled," elderly people can choose which services they need, services can be tailored to meet their assessed needs, and new approaches can be implemented for sharing the costs of these services. The most appropriate person in the most appropriate setting can provide the most appropriate services to meet the individual's needs. With unbundled services, people would be able to choose to have additional services beyond those that are based on their assessed needs. These additional services would have to be paid for by the individual.

In summary, the Committee is suggesting a fundamentally different approach to where and how continuing care services are provided. In the past, we grew up in a system where, if older people had health problems, there were only two options – they stayed in hospital or they moved to a long term care centre. Other options such as staying at home with the support they needed simply were not available. In the future, we will be looking at a system where staying at home or in flexible supportive housing arrangements will be the first option for more and more people. People will only need to move to long term care centres when it is no longer appropriate or cost effective for their assessed health care needs to be met at home. Hospitals will be only for acute episodes of illness or injury.

The Committee is confident that, with proper planning, the vision we have outlined can be achieved. It reflects what many Albertans said they want to see for the future. However, it will take time for this vision to unfold. A step by step approach, rather than an abrupt change, is important. Alberta society needs to support and understand the new direction in order for it to happen. Strategies to communicate with the public about new directions and expectations for continuing care and healthy aging are needed. The dramatic changes in the care of older people envisioned by the Committee cannot happen "with the flick of a light switch."

Providing coordinated access to a full range of continuing care services

Recommendation 12:
Expand coordinated access to include all continuing care services

The Committee recommends that:

- *Access to continuing care services should be based on assessed need. To the extent possible, people should have choices in the services they receive and where those services are provided.*
- *People should have reasonable and timely access to the continuing care services they need based on availability, affordability and the appropriateness of services needed.*
- *There should be a coordinated, single point of entry to a full range of continuing care services.*
- *Regional health authorities should work together to ensure there is coordinated access to services across regional boundaries.*
- *People who want to access continuing care services from regions other than their home region should be considered on the same basis as residents who live in the region.*
- *Technology should be used to facilitate and streamline the referral process and share assessment information appropriately. The client's privacy must be protected when assessment information is shared.*

"The stakes are high if greater integration of health care delivery is not achieved. In the absence of integrated management, there is no incentive to ensure the transitions and bypasses from institutions to community care are in place. Voila! Waiting lists, which back all the way up to the ambulance at the emergency door ... "

Mr. Laurie Thompson, Saskatchewan Health Services Utilization and Research Commission

Comments:

Alberta has taken a leadership role in providing a single point of entry for continuing care services. This approach is highly recommended by a variety of experts and should continue to be used in the province. However, the single point of entry should be expanded to include a full range of continuing care services. People's needs should be assessed only once, and that should lead to the most appropriate continuing care programs and services to meet the person's needs. People who want to access continuing care services in another region for a number of reasons, including where their families live, often are put "at the bottom of the list." They should be treated on the same basis as other people who live in the region and need continuing care services.

Recommendation 13:
Implement new assessment tools

The Committee recommends that:

- *A new provincial standardized tool for assessing the need for continuing care services should be adopted by Alberta Health and Wellness and used consistently by regional health authorities.*
- *A provincial standardized method should be developed for assessing family support, income and criteria for referrals to services available in home care, supportive housing and long term care centres.*
- *The new assessment tools currently under development should be reviewed to assess whether they are consistent with the overall direction and specific recommendations included in this report.*
- *A three year plan should be developed to implement the new system of assessment and classification systems.*

Comments:

Alberta is seen as a national leader in the developing and using standardized assessment tools. For more than ten years, Alberta service providers have used a standardized assessment tool for continuing care services, a standardized resident classification system for facility-based services, and a standardized home care classification system for home care services.

However, current assessment tools are out of date and do not reflect new approaches and new models of care including the need to assess other aspects beyond just physical needs. Work has been underway for some time in Alberta Health and Wellness to develop new tools for assessment. The Committee strongly supports the overall approach taken in developing those tools. We suggest that the assessment tools be reviewed in light of the Committee's recommendations and that a specific implementation plan should be developed to phase in the new provinical standardized tools over three years.

Recommendation 14:
Ensure a broad range of continuing care services across the province

The Committee recommends that:

- *Regional health authorities should be expected to provide a broad range of continuing care services in a number of settings and delivered by a wide range of health care providers.*
- *Regional health authorities should provide a leadership role in coordinating, referring clients and providing linkages to services in the community.*

Comments:

The chart on the following page provides an overview of the provision of continuing care services and the location of these services. Those services include clinical and therapeutic (professional) services, assistance to daily living services, and coordination and linkages to social support and other services. This range of services can be provided in any of the three streams – in the home, in supportive housing units, or in long term care centres. Regional health authorities are responsible for providing access to the full range of services and ensuring that the services are coordinated to meet the person's needs.

The Committee recognizes that regional health authorities may choose to contract these services with other agencies and operators rather than provide the services directly. Where services are contracted, the Committee believes that appropriate standards must be in place. Further recommendations on standards are included in later sections of this report. We also understand that this role of regional health authorities needs to be recognized in the base of funding they receive so that adequate resources are in place.

Providing Continuing Care Services

Clinical and Therapeutic (Professional) Services

a) Assessment and Coordination Services: Includes assessment, service planning and ongoing joint client service coordination between the provider and client and/or family. These services are provided as part of the "coordinated access" process. Includes:

- Assessment
- Case Management
- Discharge planning
- Referral/consultation with specialized expertise
- Provides information as requested

b) Professional Services: These professional services are usually, but not exclusively, provided by
health professionals such as registered nurses, physicians and therapists, in accordance with professional legislation. They also include formal delegation and supervision of care of specific tasks to paraprofessionals and support workers. This definition only includes services authorized and/or funded by regional health authorities. Professional services can be delivered in a variety of sites, including continuing care centres, supportive housing sites and "private dwellings" of individuals.

Assistance to Daily Living Services

Includes assistance to clients with activities of daily living to enable individuals to function as independently as possible by supporting them and their families in managing their health care.

Basic Activities to Daily Living (ADL) includes:

- Grooming
- Bathing
- Feeding
- Toileting
- Dressing
- Walking
- Transferring

Instrumental Activities of Daily Living (ADL) includes:

- Laundry
- Housekeeping
- Meal preparation

Coordination and Linkages to Social Support and Other Services

Includes linkages/referrals for clients to services outside the mandate of the health authorities. These services provide a social support network for clients. The health authorities provide a leadership role by coordinating community mobilization of these services. Coordinated access would be linked with services such as companion services (e.g. shopping, medical appointments), opportunity for social interaction such as recreational programs, volunteer "adopt a grandparent" type programs, pastoral services, and exterior house maintenance (e.g. lawn maintenance, home repairs and snow shovelling) provided by other agencies.

Location of Continuing Care Services

Locations where continuing care may be delivered includes three streams:

- Home Living – single dwellings and apartments
- Supportive Living – group homes, seniors' complexes, lodges/enhanced lodges and assisted living
- Facility based – nursing homes, auxiliary hospitals and new models

Recommendation 15: Implement a new information, assessment and referral process

The Committee recommends that:

- *A new model for an information, assessment and referral process should be adopted and used by regional health authorities across the province.*

Comments:

To streamline and coordinate access to the most appropriate continuing care services, the Committee has developed a new model for an information, assessment and referral process. A chart describing the new model is included on page 45.

The proposed model is called "Coordination, Assessment and Referral for Entry to Services" (CARES). It proposes the following eight step process when a client makes an initial contact:

1. Information – Depending on the person's needs, information would be provided about resources outside the health system including the Housing Registry, volunteer agencies, other government agencies and private agencies. If only information is needed, the individual would require no further contact with the CARES system.
2. Screening – Screening would identify at risk individuals. Coordination would be needed with community-based health care professionals, adult day programs, family and support services, and acute care facilities. Follow-up would be arranged with at risk individuals.
3. Intake information – If the person needs continuing care services, an initial identification of those services would be done. A quick response process for crisis situations would be in place.

4. Formal assessment – If a need for publicly funded continuing care services is identified, the formal assessment process, using a standardized assessment tool, would begin. Specialized assessments for mental health services or in-depth geriatric assessment would also be available.

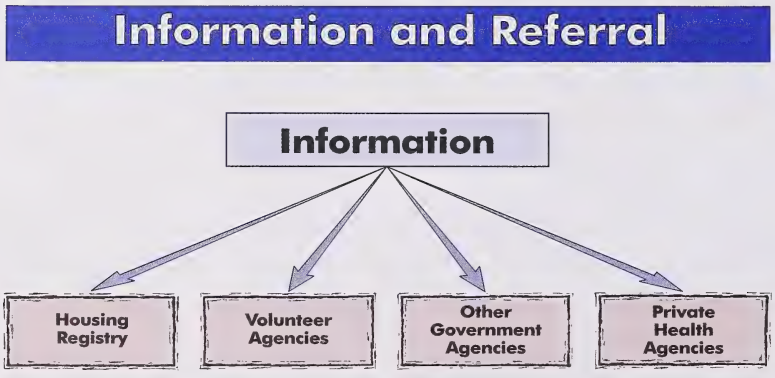
5. Identification of services required – Following assessment, the assessor and the client would jointly decide what services would be provided.

6. Referral for continuing care services – Based on decisions about the kind of care needed, a referral would be made to the most appropriate service either within or outside the region. Care plans would be developed by the service delivery agencies involved.

7. Reassessment and ongoing evaluation – Processes would be in place for regular reassessment or for changes to be made when a person's health status or service needs change.

8. Discharge planning – CARES should be closely linked to facility-based discharge planning. That planning should begin at the time of entry to services and should be part of the ongoing reassessment of person's needs.

Figure 3

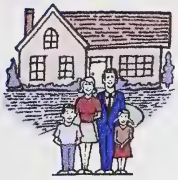


Source: Policy Advisory Committee. Long Term Care Review. September 1999

Figure 4

Coordinated Access to Continuing Care Services

Individual



Community-at-Large

Acute Care Facilities

Coordination, Assessment and Referral for Entry to Services (CARES)

Information

Steps:

1. Contact & Information
2. Screening: at risk identification
3. Intake
4. Formal Assessment
5. Identification of Required Services
6. Referral for Services
7. Reassessment/Ongoing Evaluation
8. Discharge Planning

Assessment

Specialized Assessment

No Further Service Required

Service Referral

Continuing Care Services

- Clinical and Therapeutic (Professional)
- Assistance to Daily Living
- Coordination and Linkages to Social Supports and Other Services

Possible Settings

Single Dwellings/ Apartments	Seniors Complexes	Group Homes	Lodges/ Enhanced Lodges	Assisted Living	Continuing Care Centres

Home Living Stream | **Supportive Living Stream** | **Facility Based Stream**

Source: Policy Advisory Committee. Long Term Care Review. September 1999

Setting new directions for three living streams

Recommendation 16:
Expand home care and community services

The Committee recommends that:

- *Expanded home care services should be available across the province to support people and enable them to remain independent and in their own homes as long as possible.*
- *Community and home care should be provided through a range of service delivery options including direct service delivery, self managed care and guardian managed care. The amount of service provided in each of these categories should depend on the assessed needs of the individual and should ensure reasonable access to services that can be provided in the region.*
- *There should continue to be limits on the maximum amount of home care services provided, however, the current limit of $3,000 per month should be reviewed in light of current costs.*
- *Current exemptions to the limits on home care services should be expanded to include not only palliative care patients but other groups as well, including children with complex needs.*
- *The self managed care option should allow individuals, under their direction, to designate responsibility for the financial management of self managed care.*
- *To the extent possible, there should be continuity of care if people move from one region to another.*

"Home is where your life partner is. Home is where you have established memories. Home is where there are connections to others – your community. Home is more than four walls. Home is privacy."

Public consultations

"Most probably in the future, hospital care will be defined as home replaced care. Any care not delivered at home is an anomaly. The nice part of this is that not only elderly people but people of all ages like this model."

Jan van Gorp, Director, European Association for Care and Help at Home, Netherlands

Comments:

Most seniors want to stay in their own homes as long as possible, and for good reason. The Committee believes that this is the best option for most seniors, provided they have the kind of care and support they need. With projections for an aging population and more people choosing to stay in their own homes, demands for home care services will increase in future and must be addressed.

The Committee heard several concerns about access to home care services. While home care services have increased, the need to serve people who have been discharged from hospital has put pressure on the amount of home care available for people with longer term, chronic health needs. The Committee also heard concerns that people across the province should have access to similar home care services.

The Committee also reviewed the current $3,000 per month limit on the maximum amount of home care services provided to an individual. The Committee supports the need for a ceiling on home care services, based on the comparable cost of services provided in a long term care facility. However, the current $3,000 per month limit has been in place for some time and should be reviewed in light of increasing costs. The Committee also suggests that regional health authorities should not be able to set limits that are lower than the provincial standard. In addition, there currently are exemptions to the limit in place for palliative care patients. The Committee recommends that exemptions also should be available for other groups, particularly children with complex needs.

The Committee heard concerns about quotas set on the self managed care option by some regions. Self managed care should be based on assessed needs of the individual and there should be flexibility in place.

The Committee also heard concerns about the inability of people to designate others to take over responsibility for financial decisions. Currently, under the self managed care

option, people have to be able to take care of their own financial decisions. This is a limitation for people who may be able to manage their own care but do not have the energy or ability to manage their finances on a day to day basis. These people should have the option of designating family members or others to manage their finances, however, no payment would be provided to those who provide these services.

Recommendation 17:
Expand the supportive housing stream

The Committee recommends that:

- *Supportive living arrangements, with appropriate and flexible home care services, should be expanded across the province to provide greater flexibility, meet the needs of an aging population and curtail the need for additional spaces in long term care centres.*

The Committee recommends that:

- *A Health and Housing Partnership Committee should be established and should take the lead in:*
  - *Assessing needs and providing overall direction*
  - *Developing and evaluating a variety of models for providing supportive living*
  - *Setting policies and standards for both the quality of care provided and the construction of appropriate supportive housing units*
  - *Clarifying the role and accountability of regional health authorities, other government departments, and the private and voluntary sectors in supportive housing.*

- *Appropriate subsidies and income support programs should be in place to ensure that low income seniors are able to access supportive housing units. Alberta Health and Wellness should work with other government departments to ensure that appropriate subsidies are in place and that the existing supply of subsidized housing is utilized effectively.*

"A comprehensive and appropriate health care system must include an expanded community care system."

Dr. Neena Chappell,
Director, Centre of Aging,
University of Victoria

Recommendation 17 (continued):
Expand the supportive housing stream

- *Appropriate information about the types of supportive housing needed to allow people to "age in place" should be communicated to the private and voluntary sectors. Alberta Health and Wellness should work with other government departments and health authorities to ensure that this information is readily available.*

- *In smaller communities and areas where there are not enough people or sufficient demand to attract private sector developers for building supportive housing, enhanced lodges and apartments should be considered as well as other special arrangements. Alberta Health and Wellness should work with other government departments, health authorities and the private and voluntary sectors to develop the most effective arrangements.*

Comments:

The development and expansion of supportive housing units is a critical component of the Committee's recommendations. In Alberta, the focus in the past has been on building long term care facilities and hospitals while, in other places, more emphasis has been placed on building supportive housing alternatives.

The Committee sees an expanded role for supportive living arrangements in the future. However, these options will not be able to provide a true alternative to long term care centres unless appropriate and expanded home care services are available.

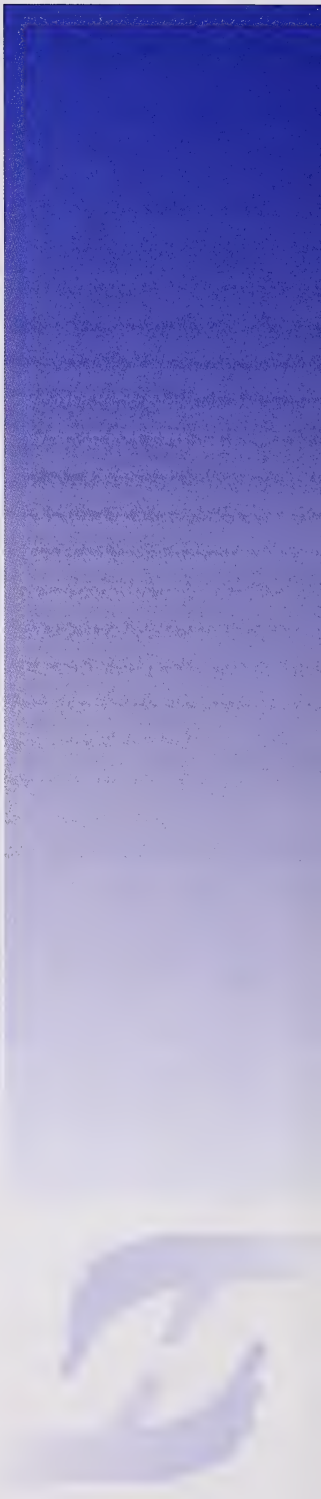
Supportive housing arrangements provide flexibility and the ability to "age in place" and will be increasingly in demand with an aging Alberta population. It is important to note that supportive living units will not replace long term care centres.

Long term care centres will continue to be necessary for a smaller proportion of the population who experience major physical and cognitive disabilities.

As noted earlier in this report, the types of supportive living arrangements vary from those which provide only minimal services such as property management, security and some other services, to assisted living arrangements where health and social services are provided. Depending on the level and type of continuing care provided, risks are shared in different ways between the individual and the operator of the housing units. Where few services are provided, the individual has choices and is responsible for the decisions he or she makes. Where there are higher needs, such as assisted living arrangements, the operators assume the risk and manage that risk with the residents through a contractual arrangement. This is a key difference.

Across the province, the range of supportive housing and service packages will vary from region to region, depending on the needs of people in the area. Currently, some existing self-contained apartments are under-utilized and could be renovated to provide supportive housing options for people in those communities. Consideration should also be given to flexible options suggested during the consultations with Albertans, including "granny flats," group homes and other types of alternatives. Regional health authorities, operators and housing providers need to work together to plan more supportive housing units and options for additional health and support services that may be required as people age.

The Committee also suggests that there is a role for lodges to play in providing expanded supportive living options. It may mean enhancing the services currently available in lodges across the province, particularly in rural communities where there may not be sufficient demand for developing new supportive housing units.



"Supportive housing, by all its names, is intended to fill the huge gap between living in one's own home with sporadic support and living in a nursing home. ... The essence of supportive housing has been expressed many times by seniors: I've got privacy but I know help is there if I need it."

Nancy Gnaedinger, Consultant in Gerontology, Victoria, B.C.

There was a strong sense among Committee members that supportive living arrangements are a growing trend. Standards are needed so that new developments built by the private and voluntary sectors are appropriate for an aging population and provide the kinds of facilities necessary if additional health services are needed in the future. This issue also is addressed later in this report in the section on legislation and regulations.

The Committee understands that these issues also are being addressed by the Government-Wide Study on the Impact of the Aging Population.

Recommendation 18:
Revitalize long term care centres

The Committee recommends that:

- *A new generation of innovative long term care centres should be developed. This would include upgrading and improving the physical condition of some current nursing homes and auxiliary hospitals to enhance the quality of life for long term care residents, respond to the increasing complex health care needs of their residents, and implement new models of care.*

- *Alberta Health and Wellness, in partnership with other government departments, should take the lead in developing and implementing a five year plan to upgrade and revitalize long term care centres. The plan should reflect the target scenarios recommended by the Committee for the year 2016.*

- *All three and four bed wards in long term care centres should be phased out as soon as possible as part of the five year plan. Residents should have access to single rooms and rooms that are appropriate for couples.*

- *Strategies should be in place to assist long term care centres in meeting the increasingly complex health needs of their residents. Those strategies should include ways of ensuring there is an adequate supply of staff, upgrading training of human resources, and enhancing the services available.*

- *Long term care centres should be considered as sites for facility-based long term care, palliative care, sub-acute care, respite care, care for people with Alzheimer's disease, wellness and community care centres, and other innovative service options. In view of this expanded role, the name "long term care centres" should be changed to "continuing care centres."*

Comments:

The average age of a traditional long term care centre in the province is just under 22 years. Roughly half of the existing facilities need upgrading. Extensive renovations are urgently needed to provide new and more up to date models of care and also to respond to the fact that residents of the facilities will be older and have more serious health care needs. The Committee also recognizes that additional staff, particularly people with training and education in dealing with the complex needs of the elderly, will be required to accommodate this new approach. Additional recommendations about education and training are included later in this report.

Under the preferred future scenario chosen by the Committee, the proportion of people who will reside in long term care centres is expected to decline, particularly as more options become available in the community and at home. At the same time, long term care centres are, and will continue to be, essential to meet the needs of frail elderly people with complex physical and cognitive disabilities and for other Albertans with continuing care needs.

To meet the changing demands of an aging population, the Committee recommends that a new generation of innovative long term care centres is needed. This will require extensive renovations, removal of four bed rooms, and expanded abilities to deal with palliative care, sub-acute care and care for people with special needs. The five year plan recommended by the Committee should identify priorities and ensure that steps are taken as soon as possible to remove four bed rooms.

Future plans for the number of beds required in the province should be based on the projections identified for the future scenarios selected by the Committee. In addition, the Committee recommends that future planning should be based on a benchmark age of 75 – 85 years of age, not 65 as in the current planning models. Utilization of long term care beds is highest for people who are over 80 and is low for people who are in the 65 – 75 age range.

The Committee also recommends that the name of long term care centres be changed to continuing care centres to reflect their changing role. In fact, the majority of people living in these centres in the future, are not likely to be there for a "long" period of time. The centres will increasingly be called upon to provide short term care such as respite, palliative care and day care. Changing the name to continuing care centres is more consistent with this new direction.

Recommendations about how to fund the required renovations and new long term care facilities are included in later sections of this report.

Meeting the needs of special target groups

Within the scope of the overall direction provided for continuing care services for the future, the Committee also recognizes that there are groups of individuals whose special needs and circumstances have to be addressed in Alberta's continuing care system. The following sections provide recommendations for addressing the needs of particular target groups.

Providing services for people with Alzheimer's and other dementias

Epidemiologists have called Alzheimer's disease and other dementias the "biggest public health challenge for the 21st century." Studies suggest that Alzheimer's and other dementias are among of the most distressing and burdensome health problems for elderly people and those who care for them. The stress on informal caregivers can lead to chronic health problems.

The prevalence of Alzheimer's disease and other dementias is very much related to age. With an aging population, the number of people with Alzheimer's disease and other dementias will increase. According to the *Canadian Study on Health and Aging*, 8% of all Canadians aged 65 and over met the criteria for dementia. The incidence was much higher among those aged 85 and over (34.5%) compared with people between 65 and 74 (2.4%).

Many of the people with severe dementia will require institutionalization. The *Canadian Study on Health and Aging* estimates that 56.9% of people in institutions have dementia. Training and continuing education will be needed to enhance the skills of continuing care staff, physicians, registered nurses and other health professionals in dealing with the needs of elderly people with dementia.

Recent advances suggest that future drug therapies may delay the advance of severe dementia. This will increase the number of people with mild and moderate dementia living in communities in the next decade.

In view of this growing problem, a concerted strategy is needed to develop the best ways of caring for people with Alzheimer's disease and other dementias. Alberta has been a leader in developing new models of continuing care. Specially designed Alzheimer's care centres and programs are being built and implemented in Edmonton and Calgary. Specialized care units for Alzheimer's disease and other dementias have been integrated with long term care centres in different parts of the province.

Recommendation 19: Develop a province-wide plan for addressing needs of people with Alzheimer's disease and other dementias

The Committee recommends that:

- *A multi-faceted province-wide plan should be developed to address the future needs for care and support for people with Alzheimer's disease and other dementias. The plan should include the following components:*
  - *Education about Alzheimer's disease and other dementias for the public and caregivers*
  - *Enhancement of the diagnosis, assessment and care planning skills of physicians, nurses, and other health care professionals in treating people with these diseases*
  - *Education and training for front line workers, in particular those who work in continuing care centres and in community care programs*
  - *Support for care givers*
  - *Development of models for delivering services in the community*
  - *Development of new residential supportive housing and facility-based models for residents with Alzheimer's disease and other dementias*
  - *A substantial increase in the number of special care (secure) units for individuals with dementia and severe behavioural problems.*

- *Alberta Health and Wellness should take the lead in developing the plan in partnership with health authorities, health care providers, Alberta Learning, the Alberta Mental Health Board, the Alzheimer's Association of Alberta, and other voluntary agencies and support groups.*

Comments:

A comprehensive, province-wide plan is needed to address the needs of a growing number of older Albertans who will develop dementias and possibly Alzheimer's disease in their later years. The Committee understands that most regions have already developed programs to address the needs of people with Alzheimer's and that a lot of very good work is already being done by physicians, nurses and others working with people with Alzheimer's and other dementias. Our objective is to build on and support the work that already has begun.

As noted in the recommendations, the plan should be multi-faceted and include actions in the following areas:

- In expanding awareness and education – Alberta Health and Wellness should work in partnership with the Alzheimer's Association of Alberta, Alberta Learning, the Alberta Mental Health Board and other organizations to heighten the awareness of the prevalence of Alzheimer's and dementia.
- In expanding education and training for health professionals and staff – Alberta Health and Wellness should work with Alberta Learning to address the need for training and education for students, health professionals and continuing care staff. Ongoing inservice programs also should be available. Further recommendations on education and training are included in later sections of this report.
- In providing support for caregivers – Alberta Health and Wellness should work with the Alzheimer's Association of Alberta, health authorities and other voluntary groups to develop effective ways to provide support for family members and other informal care givers.
- In developing new models of care in the community – Alberta Health and Wellness should work with other government departments, the Alberta Mental Health Board, health authorities, housing associations, voluntary and community agencies to develop new models for delivering care for people with Alzheimer's disease and other

dementias. This could include more specialized home care services, group homes for dementia clients, assisted living and specialized dementia wings in enhanced lodges, and smaller supportive housing spaces for people with light and moderate dementia.

- In developing new models for long term care centres – Alberta Health and Wellness should work with the Alberta Mental Health Board, health authorities, operators and other agencies to develop new models for long term care centres to use in meeting the needs of those with severe dementia and Alzheimer's. Research currently is underway to evaluate the long term care needs of people with Alzheimer's. The results of this research should be shared across the system.

Meeting the needs of people with disabilities

Recommendation 20:
Address the continuing care needs of people with disabilities

The Committee recommends that:

- *For disabled people living in continuing care centres, the centres should provide programs and facilities that reflect their needs. Programs should be individualized, flexible and sensitive to the social and physical needs of the age groups receiving care in their facilities.*
- *Regional health authorities should take the lead in encouraging the private and voluntary sectors to provide a variety of housing options for the young disabled in their communities.*
- *Regional health authorities, wherever possible, should locate community-based health services and programs in close proximity to other agencies and services that are generally used by disabled people.*

Comments:

Continuing care centres provide services to all Albertans who need access to support services or professional health services, regardless of their age or disability. Advances in medical technology have saved and/or extended the lives of many younger people including children with complex health needs, the brain injured, young adults with functional and developmental disabilities, and those with Down's Syndrome and Cerebral Palsy.

The age of disabled people in continuing care centres will vary from the very young to the very elderly. As well, every disability is unique to the individual. It is important that continuing care staff recognize the differences in the needs of the people they serve, and have the training and skills necessary to provide individualized care as much as possible.

The scope of needs of people with disabilities includes not only health and support services but also may include social, educational, and employment needs. To meet these needs, it will be increasingly important for close linkages and referrals to be in place with other agencies and to ensure that this happens through the continuing care assessment process. It also will be important to plan and locate community-based health services in programs in locations that are close to other agencies that provide services to disabled people.

With an aging population, the likelihood of people with disabilities requiring continuing care services in facilities is expected to increase. For example, individuals with Down's Syndrome now often live to adulthood, however, a high percentage of those surviving to adulthood will develop some type of dementia. Their primary caregivers (usually parents) may be either deceased or elderly. While additional supportive housing units may address some of their needs, continuing care centres will continue to be one of the options for these people.

The Committee also understands that many younger disabled people prefer options other than continuing care centres. For that reason, we suggest that regional health authorities work with the private and voluntary sectors in their communities to encourage the development of other housing options including group homes, supportive housing and assisted living arrangements. Continuing care centres could be available for day programs or other specialized services.

Expanding mental health services for older people

Recommendation 21:
Expand community-based mental health services for older people

The Committee recommends that:

- *There should be expanded programs available in communities to meet the needs of older people living with mental illnesses. The Alberta Mental Health Board should work collaboratively with regional health authorities to ensure that the necessary programs and services are in place and accessible, including providing access to psychogeriatric specialists, inpatient assessment, outpatient and crisis intervention programs.*

- *Health professionals and continuing care staff should have increased access to education and training to assist them in providing care for older people living with mental illnesses.*

Comments:

During its consultations, the Committee heard extensive comments from the public and others about the need for expanded access to programs to address the needs of elderly people with mental illnesses.

Consider these facts from selected studies and reports:

- Psychiatric and neurological conditions account for 47.2% of all years lived with a disability in the richer developed countries but for only 1.4% of all deaths.
- Five of the ten leading causes of disability in developed countries in 1990 were psychiatric disorders.
- Unipolar major depression accounts for over 13% of all disability, alcohol use accounts for 7.1%, schizophrenia for 4.0%, bipolar disorder for 3.3% and obsessive-compulsive disorder for 2.8%.
- The *Canadian Study on Health and Aging* indicates that the number of all psychiatric disorders (including dementias) in 2016 is estimated to be 4.6 million, a 24% increase from 1997. The largest increase will be in people over 45 years of age.
- Rates of dementia are expected to increase with an aging population.
- The prevalence rates for depression have been steadily increasing since the 1930s in Canada and the U.S.
- People over the age of 50 years have low rates of remission of psychiatric disorders.
- Increasing numbers of persons with mental illness are being treated in the community.
- With a growing population, Alberta is seeing more problems of homelessness, especially in the major centres. Many of these people have problems with mental illness.

The Committee suggests that the need to deal with mental illnesses in the elderly will increase with an aging population. Expanded programs are needed in communities across the province to deal with these growing needs.

The Committee also feels that enhanced education and training in mental health and how to care for elderly people with mental illnesses should be provided to health professionals and people working in continuing care. This would involve including programs on caring for people with mental illnesses, geriatric and psychogeriatric care in the core curriculum for health professionals. Ongoing inservice and

training opportunities also should be provided using technology and other home study programs. This relates directly to further recommendations on education and training outlined in later sections of this report.

Respecting cultural and ethnic diversity

Recommendation 22:
Respond to cultural and ethnic diversity of people in continuing care

The Committee recommends that:

- *Regional health authorities should ensure, wherever possible, that continuing care programs and services are sensitive to cultural diversities (e.g., customs, religious beliefs, languages and food).*

- *Inservice programs, events, workshops and other educational opportunities should be available for continuing care staff to enhance their knowledge and understanding of different cultures.*

Comments:

Alberta is a province rich in cultural and ethnic diversity. Many of its citizens are new or first generation Canadians. In 1996, over 1.25 million Albertans said they had multiple ethnic origins. Of those who said they had a single ethnic origin, most said their origin was European, followed by Canadian, British Isles, East and Southeast Asia. People from other countries and cultures bring with them their own social norms and language, as well as religious beliefs.

Aboriginal people make up about 5.8% of the Alberta population. There is diversity among Aboriginal people themselves. There are many Aboriginal peoples in Alberta, including First Nations, Metis and Inuit. The life expectancy

for Aboriginal people has been considerably lower than the average for Alberta's population, but it is increasing. That means more Aboriginal people will have a need for continuing care services in the future. The Committee recognizes that Aboriginal people and the federal government have important responsibilities for ensuring that these needs are met in Aboriginal communities.

A number of regional health authorities and operators have made changes in the care and the environment in their continuing care facilities to accommodate the cultural and religious norms of different ethnic groups. In future, it will be increasingly important to be sensitive to the needs of different groups and to make adjustments wherever possible to meet their needs. Regional health authorities should consider flexible approaches such as using volunteers and family members.

Implementing the new directions

Addressing cost recovery and subsidization policies

Perhaps one of the most difficult issues facing the Committee is to consider not only how a new vision for continuing care should be implemented, but also how it should be funded and who should share in those costs.

Alberta's continuing care system is not an inexpensive one and with an aging population, those costs are expected to increase. Currently, people who live in continuing care facilities pay, on average, $28.60 a day for their accommodation. All health care services are provided at no cost. The actual cost of staying in a facility is about $105 per person per day, not including capital costs. The current charges have not been increased since 1994, and they are the lowest of the ten provinces. In addition, the charges are a flat rate paid by everyone regardless of their income. Most other provinces tie the charges people pay to their income. We also expect the demands for home care to increase as the population ages and more people choose to stay in their own homes or in supportive housing.

In addition, Alberta's supply of long term care beds is in serious need of renovations and upgrading. Looking ahead, these issues will need to be addressed so that we can sustain our continuing care system and provide the services people need.

Starting with principles

To assist in sorting out a variety of issues and options related to "who pays for what," the Committee began with a set of principles that are consistent with our vision.

- No Albertan should be denied access to continuing care services because of an inability to pay.
- Health care is a shared responsibility. Professional health care services are the responsibility of government, but personal care services are a shared responsibility between the individual and government.
- People are responsible for their own food, shelter, personal hygiene, recreation and transportation throughout their lives. This should not change just because a person is aging.
- Some form of income testing is appropriate in setting cost recovery levels.
- Revenues received from charging to recover some of the costs of continuing care have to be balanced against the costs of providing appropriate subsidies for those who need them.
- People living in long term care facilities should be able to retain a reasonable amount of their income.
- Any increases in revenues from cost recovery charges should be used to improve services and facilities.

"The new vision of health reform embraces multiple sectors rather than identifying largely the state as having sole responsibility for health care. There is a new recognition of families and informal networks, of voluntary organizations, churches, neighbours and neighbourhoods."

Dr. Neena Chappell, Director, Centre of Aging, University of Victoria

Introducing a conceptual framework

With those principles in mind, the first question is, "How do you decide whether or not people should be charged for certain types of continuing care services and facilities?"

The Committee has developed the following conceptual framework to help guide those decisions.

Who is responsible for the costs of continuing care?

Cost components	Home care	Supportive living	Long term care facility
Professional care, e.g. nursing services and services provided by therapists and other health professionals	Government – 100%	Government – 100%	Government – 100%
Activities of daily living, e.g. personal care and homemaking services	Government/ individual share costs	Government/ individual share costs	Government/ individual share costs
Accommodation, e.g. food, cleaning, utilities, etc	Individual – 100%	Individual – 100%	Individual – 100%
Housing costs, e.g. construction, renovations and upgrading	Individual - 100%	Individual, with income support where needed	Shared responsibility: Individual – 33% (through rental payments) Owner – 33% Government – 33%

Recommendation 23:
Adopt a conceptual framework on responsibility for costs

The Committee recommends that:

- *The conceptual framework should be adopted as the basis for decisions about responsibility for the costs of different types of continuing care.*

What options are possible?

Based on the conceptual framework, the Committee developed a series of options for addressing cost recovery and subsidies in continuing care centres and for home care services provided in either the home living stream or the supportive housing stream. Both of these areas are facing increasing costs and demands for services, and the current funding methods need to be reviewed.

Several options were developed for facility charges and home care based on the following considerations:

- Charges should reflect actual costs of the services.
- Subsidies must be in place where financial need is demonstrated.
- Income testing should be used to demonstrate financial need.

Options for charges in continuing care centres

Three options were prepared for adjusting charges in continuing care centres. The three options are based on the following factors:

- Clinical and treatment services would be excluded from the charges. These costs would be covered by the provincial government.

- The individual resident should be able to retain at least 10% of their disposable income for personal expenses. As a person's disposable income goes up, they would be able to retain a greater percentage of their income.
- If charges are adjusted, they should be tied to the individual's income. Asset testing is not suggested.

Based on those considerations, the following three options were considered:

Option 1 – Maintain the status quo

Under this option, the current flat rate charges would be retained. Individuals in a standard room with up to four people would continue to pay $24.65 a day, individuals in a semi-private room would pay $26.25 a day, and individuals in a private room would pay $28.60 a day.

Advantages:

- It's easy to administer.
- The cost to the individual is low.

Disadvantages:

- No adjustments have been made to the fees since 1994, in spite of the fact that costs have risen significantly.
- The $28.60 fee bears no direct relationship to the cost of services.
- A flat fee does not reflect the reality that some people can afford to pay more while others cannot.
- With a flat fee, there is no opportunity to "unbundle" the services. People don't understand what the charges are for and what they cost to provide.
- With the low rates, there is an incentive for people to move into continuing care centres because their cost of living and health services is lower.

Option 2 – Increase charges within the range of a minimum and a maximum threshold amount. Ensure that subsidies are in place for those who cannot afford the higher fee levels.

Under Option 2, charges would increase. A minimum and maximum threshold would be set based on information about average income levels for seniors. Below the minimum threshold, everyone would pay a set charge. Above the minimum threshold, people would pay a higher charge based on income. The maximum threshold would set the limit on the most a person would pay regardless of their income. For ease of administration, consideration should be given to administering the income test with other existing programs, such as the Alberta Seniors' Benefit program.

Advantages:

- Charges could be increased to more accurately reflect the real costs.
- Charges would be responsive to the income levels of the individuals.
- Additional revenues would be raised and could be used to support enhanced services and capital renovations and construction.
- A single government department would be responsible for income testing.

Disadvantages:

- Some people may object to paying more.
- There may be objections to income testing as the basis for determining charges for each individual.
- Because it is a significant change from the current flat rate system, it may be more complex and difficult to explain the basis for different rates.

Option 3 – Set charges at a level that covers the full operating and capital housing costs of the facility.

Under Option 3, residents would be responsible for the full operating and capital housing costs of the facility. Subsidies would be in place for those who could not afford the charges.

Advantages:

- Charges would reflect the actual costs.
- Additional revenues would be raised for expanding services and renovating facilities.

Disadvantages:

- The costs would create an unreasonable burden for most individuals and their families.
- Subsidy rates would have to be high in order to ensure that people with lower incomes would have access to these facilities.

Recommendation 24:
Increase charges in continuing care centres

The Committee recommends that:

- *Option 2 should be adopted as the best approach for adjusting cost recovery charges for continuing care centres on an ongoing basis.*

What would additional revenues be used for?

If charges for individual residents are increased, it is important that people have a clear understanding of what those additional revenues would be used for and what benefits would result from the increases.

Recommendation 25:
Target additional revenues from increased charges to improving services and upgrading facilities

The Committee recommends that:

- *Additional revenues raised from increasing charges for residents of continuing care centres should be used in two ways:*
  - *Improving services in continuing care centres – A portion of the increased charges should be used to provide enhanced programs and services, and to meet the increasingly complex needs of people in continuing care centres.*
  - *Establishing a capital pool to be used in each region to renovate and build new continuing care centres – The remaining portion should be used to upgrade facilities.*

Comments:

Continuing care centres face two pressing needs – the first is to expand programs and services, and the second is to renovate existing facilities and create a new generation of up to date facilities.

Estimates are that essential upgrading for the existing supply of long term care beds in the province could cost as much as $540 million over the next ten years. Establishing a capital pool in each of the regions would help address these costs.

The approach is consistent with the principle that housing costs should be shared among the individual, the owner, and the provincial government. When renovations are planned or new construction is needed, the pool could be used by regional health authorities to cover a portion of their costs. The provincial government and facility owners would be expected to contribute a third of the costs each. Regulations would need to be changed to allow regional health authorities to borrow money to finance the remaining amount needed for renovations and construction. All projects would continue to require the approval of the provincial government.

Options for home care services

Four options have been developed for home care services. In all four options, professional home care services would continue to be funded by the provincial government and provided by regional health authorities. Charges would only include assistance to daily living services, including homemaking and help with personal care.

Option 1 – Status quo

Under the status quo option, people would continue to receive home care services based on their assessed needs. A maximum cap of $300 per month would remain in place and people would be expected to pay an average of $5 per hour for homemaking services.

Advantages:

- The costs to the individual are low.

Disadvantages:

- There are inconsistencies in how the current policies are applied across the province. Some people are charged for homemaking services in some regions while others are not. In some cases, homemaking services are not provided.
- There are not sufficient resources available to meet the increasing demands for home care services.

Option 2 – Base charges on the average cost of the service, but put in place a minimum and maximum cap based on a person's income.

Currently, the average cost of assistance to daily living services provided as part of home care is just under $13 per hour. Under this option, people would be charged the full amount per hour, but a minimum and maximum cap would be set. The caps would be based on the person's income and subsidies would be in place for those who need them.

Advantages:

- People who are the highest users of assistance to daily living services and have a low income would be subsidized and would benefit the most.
- Charges would be based on the actual costs of the services.
- Below a certain income level, people would not be required to cover the full costs of assistance to daily living services. A maximum amount a person could pay would also be set.
- Even at the maximum cap, the cost of the services to an individual would be lower than in a continuing care centre so there is no disincentive to remain at home.
- Additional funds would be generated and could be used to expand home care services in the community.

Disadvantages:

- Depending on their income levels and the maximum amount charged, some individuals would pay more for home care services.

Option 3 – Set the charges at half the average cost, and also put a minimum and maximum cap in place based on income.

This option is similar to option 2 except that the costs to the individual would be lower because the charges are set at half of the actual costs.

Advantages:

- The advantages are similar to option 2 except that everyone is subsidized for half the average costs of the services.
- The increases in costs to an individual are less than in option 2.

Disadvantages:

- Not enough revenue is raised to have a significant impact on freeing up funds to expand home care services.

Option 4 – Set the charges to cover the full costs and do not put any caps in place.

This option would mean that an individual is paying the full cost of home care services aside from the health care services covered by the provincial government.

Advantages:

- Additional revenue would be available to support expanded services.

Disadvantages:

- Significant numbers of seniors would not be able to afford the services.
- Extensive subsidies would need to be in place.
- Many seniors would not receive the support they need to remain in their own homes.

Recommendation 26:
Increase home care charges for daily living services

The Committee recommends that:

- *Option 2 should be adopted. Charges for the assistance to daily living component of home care services should be based on the average cost, with minimum and maximum caps in place based on income.*

Comments:

In the Committee's view, option 2 is the best choice. It ensures that people have access to the services they need. It also increases charges for those with higher incomes and more accurately reflects the average costs. The Committee also believes that if people want more personal care services than their assessment would indicate, they can choose to arrange for those services privately and pay accordingly.

What exemptions should be made?

In reviewing policies on cost recovery, the Committee also considered a range of areas where exemptions from cost recovery policies should be made.

The Committee's recommendations for exemptions are based on the principle that cost recovery policies should reflect the *intent* of the service, not *where* it is provided. Whether a service is provided in a continuing care centre or a community setting, the policies for exemptions from charges should be the same.

"Cost recovery policies should reflect the intent of the service, not where it is provided."

Policy Advisory Committee

"Fund the care not the site. Provide allowances for care. Provide income support for those who cannot afford it. These are all in our parlance these days."

Nancy Gnaedinger, Consultant in Gerontology, Victoria, B.C.

Recommendation 27:
Provide exemptions for sub-acute care

The Committee recommends that:

- *Sub-acute care cases in continuing care centres should be exempted from payment of accommodation and housing charges.*
- *Sub-acute home care patients should also be exempted from payment of charges. This means the short term home care caseload for people with sub-acute needs in the current home care program would be exempted from fees.*

Comments:

Sub-acute care cases are part of acute care services. There would be no charges for these services if they were provided in acute care centres, therefore, there should be no charges just because the services are provided in continuing care centres, at home or in supportive living arrangements.

Recommendation 28:
Provide exemptions for palliative care

The Committee recommends that:

- *In continuing care centres, palliative care cases that are sub-acute in nature, should be exempted from charges. Longer term palliative care cases should pay the full accommodation and housing charges.*
- *For home care, sub-acute palliative care cases should also be exempted from charges if they meet the criteria. This would likely include most of the palliative care cases in the current home care program.*

Comments:

Palliative care cases vary in complexity and the type of services they require. Instead of deciding that all palliative care cases should be exempted or not exempted, this approach takes into account the reason for the services that are required. If the palliative care cases are similar to sub-acute cases, the same policy of exempting people from charges should be followed.

Recommendation 29:
Provide some exemptions for respite care

The Committee recommends that:

- *People using respite care in continuing care centres should pay the part of accommodation charges that relates to the services they receive but should be exempt from charges relating to the housing costs of the facility.*
- *In home care, people should be expected to pay the charges. These people likely would be classified as long term home care patients.*

Comments:

In long term care centres, people there for respite care should be expected to cover a portion of the costs of their accommodation just like other residents, but they should not be charged to cover housing costs since they are already responsible for their own homes. With home care, respite care is a regular part of a home care program and, therefore, charges should apply.

Recommendation 30:
Phase in any changes to cost recovery charges and subsidies

The Committee recommends that:

- *Changes to cost recovery charges and subsidies should be phased in over a reasonable period of time.*

Establishing the necessary supports

To implement the new direction proposed by the Committee, it is important to have the essential supports in place – comprehensive legislation, well educated and trained professionals, sound ethical decisions, transportation and ambulance services, research, technology, drugs and equipment, and, of course, appropriate funding levels and funding mechanisms.

The following sections provide the Committee's recommendations in each of those key areas of support.

Introducing comprehensive legislation

Currently, a number of different Acts are in place covering different aspects of the continuing care system. Establishing a separate Act for continuing care services would ensure consistency and clarify roles and responsibilities across the system. It also would fulfil government's responsibility to ensure that the public interest is protected. This is particularly important in view of the new directions the Committee is proposing. With an expansion of supportive living arrangements, it is important for standards to be in place and for mechanisms to be established to monitor quality and ensure that standards are being met.

Recommendation 31: Introduce a new Continuing Care Act

The Committee recommends that:

- *A new Act – called the Continuing Care Act – should be developed to cover the key aspects of legislation and regulations related to continuing care.*

- *The Act should cover a range of issues but specifically, it should:*
  - *Clarify the roles and responsibilities of Alberta Health and Wellness, other government departments, the Alberta Mental Health Board, the Alberta Cancer Board, regional health authorities and other agencies in providing continuing care services*
  - *Establish policies and standards for quality of care and services to be provided*
  - *Establish provincial policy on coordinated access to continuing care*
  - *Establish who is eligible for different types of continuing care services*
  - *Establish a mechanism for monitoring the quality of care provided in the home living stream, the supportive living stream, and the facility stream. This should include responsibility for regular reporting.*
  - *Clarify the responsibility for monitoring and ensuring the quality of care provided*
  - *Establish mechanisms for individuals and their families to lodge complaints and ensure that there is appropriate follow up*

- *For facilities that do not receive public funding, legislation should clarify how to set standards and monitor the quality of care provided.*

- *Current legislation related to housing should be reviewed to ensure that there are consistent standards, particularly for new supportive living developments, and that effective monitoring mechanisms are in place.*

Comments:

A new *Continuing Care Act* would provide a vehicle for addressing a number of issues, ensuring appropriate accountability and standards, and clarifying the responsibilities for all those involved in continuing care. Most importantly, it would provide the foundation for ongoing improvements in the quality of services and care people receive.

The Committee heard concerns about the need for standards particularly with the expected growth of care provided in supportive housing developments. Currently, the *Social Care Facilities Licensing Act* is in place to regulate facilities, but it has not been used to set program standards and monitoring for supportive housing or other similar care centres. Supportive housing developments should be built in such a way that seniors can "age in place." This means that the housing units should be adaptable and able to respond to increasing health care needs of people who live there. Appropriate standards for housing and care programs are needed. This issue and a number of issues related to responsibility for licensing and inspection of facilities should also be reviewed as part of the Government-Wide Study on the Impact of the Aging Population.

Funding and funding methodologies

With an aging population, there will be increasing pressure on the resources available to support programs, services and facilities for elderly Albertans. While it is not the Committee's mandate to recommend specific levels of funding, a number of questions need to be addressed:

- Are the current ways of funding health services appropriate for an aging population?
- Should there be targeted funding for continuing care or should it be part of the population-based funding provided to regional health authorities? Should components of geriatric assessment and care be considered as province-wide services?

- How should capital equipment and capital construction and renovations be funded? How should responsibility for funding capital be shared?
- Is there a way of using funding mechanisms to encourage innovation and implementation of new approaches?
- How do we ensure that there is equity and fairness in how operators of long term care facilities are funded across the province?

Recommendation 32:
Increase funding to reflect the impact of an aging population

The Committee recommends that:

- *The amount of funding provided to regional health authorities should be increased and adjusted each year to reflect changes in demographics due to an aging population, inflationary trends, and trends in increasing acuity of people receiving continuing care.*

Comments:

With an aging population, there will be increasing pressure to spend more on continuing care services. Decisions about providing increased funding should reflect the best available evidence about the impact of an aging population, increasing costs, and trends in continuing care. With more services available at home and in the community, people in continuing care centres tend to be more seriously ill and require more costly care and treatment. This will have an impact on funding for continuing care centres in the future. In addition, as more people remain in their homes or in supportive living, funding adjustments also will be needed to accommodate increasing needs for home care and community programs.

"The province is blessed with resources that allow you to get the job done. You need to recognize that caring for the frail elderly, though important, is not glamorous, but setting a tone which says that you expect high standards of care for these patients is very important."

Dr. Ken Rockwood, Professor of Medicine, Dalhousie University

The Committee repeatedly heard concerns that there simply were not enough resources in the system to meet the expanding needs in continuing care. Combined with that, the Committee also heard that when resources are limited, the first priority typically is acute care services. This means funds are redirected away from continuing care to meet pressing needs in hospitals and for acute home care services. While it is not the Committee's mandate nor do we have the information necessary to recommend specific levels of funding, we do believe that additional resources are required to meet increasing demands in seniors' health and continuing care. The total amount of funding available should be increased and subsequently adjusted each year to accommodate demographics, rising costs, and increasing acuity in long term care centres.

Recommendation 33:
Maintain population-based funding, set outcome measures, and consider geriatric assessment as a province-wide service

The Committee recommends that:

- *Continuing care should be funded as part of the population-based funding pool for regional health authorities. However, the formula should be reviewed and adjusted to ensure that there are adequate funds available to meet ongoing pressures for continuing care services.*
- *Outcome measures for continuing care should be developed by Alberta Health and Wellness. Regional health authorities should be required to report regularly on those measures and on the amount of money spent on continuing care services.*
- *Consideration should be given to designating services such as geriatric assessment as province-wide services.*

Comments:

Many have suggested that a separate pool of funds should be established for continuing care including both home care and facility-based care. The key concern is that if additional funds are provided for continuing care, there should be some way of ensuring that those funds are used for continuing care and not to address other pressures in the health system. As noted above, people feel there needs to be a mechanism in place to ensure not only that the overall pool of funds for continuing care is adequate, but also that funds are not redirected to other pressing needs in the health system. The Committee heard that, in the past, continuing care has not always been considered a high priority in some regions, and the result is that funding has been redirected elsewhere.

In the Committee's view, it is more important to ensure that the right outcomes are achieved rather than ensuring that a certain amount of money is spent. Regional health authorities are in the best position to understand the needs in their communities, and they need flexibility in order to respond to those needs. The population-based funding formula takes into account the age of the population for each region and, therefore, it is responsive to the changing needs of people in different parts of the province. Rather than set up a separate pool of funds, it is preferable to provide regional health authorities with flexibility in allocating funds to meet their community members' needs.

At the same time, the Committee recommends that the population-based funding formula should be reviewed to ensure that it addresses the increasing pressures caused by an aging population. Mechanisms also should be in place to ensure that regional health authorities are accountable for how, and how much, they spend on continuing care services.

The Committee also believes that regional health authorities should be accountable for the services they provide in continuing care and the outcomes they achieve. Outcome measures and clear accountability should be in place to assess whether or not expectations are being met. Alberta Health

and Wellness should take the lead in establishing a core set of appropriate outcome measures, setting targets, and monitoring results. Regional health authorities and other groups and organizations should be consulted as part of the process of developing the measures. The measures should be consistent across the province, understandable to the public, and where possible, have comparable national information. Regional health authorities would then report on outcome measures in continuing care as part of their annual reporting requirements. They also would report on how much money they allocated to continuing care both for home care and for facility-based care.

The Committee also suggests that consideration should be given to designating certain continuing care services as province-wide services. Currently, province-wide services are limited to complex, intense and highly technical treatments such as transplants, heart surgery, renal dialysis, neurosurgery, and intensive care for severely ill infants and patients with severe trauma and burns. The services are available only in Edmonton and Calgary but are accessible to anyone across the province. In areas such as geriatric assessment, there will be increasing needs for this service as the population ages. However, the capability for geriatric assessment exists primarily only in Calgary and Edmonton. Consideration should be given to providing a province-wide focus on geriatrics and geriatric assessment. Designating these services as "province-wide services" would help ensure that regions outside of Edmonton and Calgary would have better access to these specialized services.

Recommendation 34: Fund continuing care facilities consistently across the province

The Committee recommends that:

- *Once appropriate standards have been established, operators of continuing care facilities should be treated in a consistent manner across the province in terms of the funding they receive from regional health authorities.*

Comments:

Currently, there are inconsistencies across the province in the amount of funding that some operators receive from regional health authorities. If standards are in place and the operator meets those standards, they should be funded in a consistent way across the province.

Recommendation 35: Provide capital support

The Committee recommends that:

- *Support for capital funding for the housing component for continuing care facilities should be a shared responsibility among the individual (through rental payments), the operator, and the provincial government.*
- *Support for capital equipment should continue to be the responsibility of the continuing care facility operator.*
- *Capital for housing costs for palliative care and respite care spaces should be fully funded by the provincial government.*

The average number of prescriptions for seniors on the Alberta Blue Cross program is 27.1 prescriptions per person per year.

Comments:

The conceptual framework proposed by the Committee for determining who pays for what indicates that housing costs for continuing care centres should be a shared responsibility. However, the Committee feels that support for capital equipment should continue to be the responsibility of the continuing care operator. The Committee also recommends that capital for housing costs for palliative care and respite care should be provided by the province.

Drugs, supplies and equipment

As noted in the consultations with the public, there are serious concerns with the number and types of drugs used by older people. Information shows that the average number of prescriptions for seniors on the Alberta Blue Cross program is 27.1 prescriptions per person per year. There is a need for an overall drug utilization and drug management strategy to address this issue.

Table 1

Utilization of Drug Benefits By Community Seniors in Alberta: Years 1992-93 to 1997-98

	1992-93	1993-94	1994-95	1995-96	1996-97	1997-98
Total number of registrants receiving benefits	170,177	177,187	182,841	187,250	190,629	195,931
Total number of prescriptions	4,227,999	4,565,195	4,701,305	4,936,536	5,087,162	5,307,367
Average number of prescriptions per registrant	24.8	25.8	25.7	26.4	26.7	27.1
Total payments for benefits ($)	118,845,140	122,194,557	116,439,381	120,577,690	133,643,547	146,391,762
Average payment per registrants ($)	698.36	689.83	636.83	643.94	701.07	747.16

Source: The Alberta Centre for Health Services Utilization Research, June 1999

As part of its earlier work, the Committee addressed the issue of support for palliative care drugs. Prior to January 1999, the cost of medications for palliative care patients was covered if the person was in hospital, but if the person was at home or in a supportive living arrangement, the costs were not covered unless the person had insurance coverage. At that time, the Committee recommended that a new program be introduced to help cover the costs of medications for palliative care patients at home. Those recommendations were accepted and in January 1999, Minister of Health, Halvar Jonson, announced a new Palliative Care Drug Program. Under the program, the palliative patient is responsible for 30 per cent of the cost of prescriptions to a maximum of $25 per prescription and a maximum amount of $1,000 for out of pocket expenses. The program removes a significant financial burden and gives people a choice to be treated in their own homes.

The Committee also has prepared recommendations on a number of issues related to drug utilization, costs, and equipment.

Short term acute care drugs

The province's Budget '99 provided $6 million to help launch a new program to support the cost of drugs for short term acute care patients. In the past, the cost of these drugs was covered if the person was in hospital, but not all of the costs were covered if they were being treated at home, unless they had drug insurance coverage. This new program came as a result of early recommendations from the Committee.

Currently, there are a number of issues related to access and cost of drug therapies for short term acute care treatments provided outside a hospital setting. The cost of people paying for their own medications at home is a barrier to early discharge from hospital.

Recommendation 36: Phase in new programs to support short term acute care drugs used at home

The Committee recommends that:

- *Short term acute care drugs should be available at home and used to facilitate early discharge from hospital and to prevent hospitalization.*
- *Considering the costs of implementing this program, support for short term acute care drugs should be phased in with the first priority being parenteral anti-infectives since this is the greatest need. Other medications should be added as funding permits.*
- *Infusion supplies should be included as a program benefit and provided to patients with their medications. Infusion pumps should be provided to patients on a loaned basis.*
- *Plans for the new program should proceed with implementation targeted for April 1, 2000.*

Comments:

The Committee recognizes that it will be costly to expand support for short term acute care drugs provided in the home and supportive living settings. For that reason, we recommend that the program be phased in to address the greatest needs on a priority basis. In developing the details of this program, the Committee suggests that key stakeholders should be involved, including regional health authorities and community pharmacies. There should be provincial standards in place for discharge planning. Appropriate lines of accountability should be in place, and the program should be evaluated after one year.

The Committee also understands that there are inequities in how the costs of drugs are covered. If a person is in a continuing care centre or an acute care hospital, the complete cost of drugs is covered. However, if a person is being cared for at home, they are required to pay up to 30% of the costs of the drugs to a maximum of $25 per prescription. The issue goes beyond seniors' health and relates to a broader discussion about how drugs should be paid for in our society. While the Committee is not in a position to offer solutions at this point, the current inequities should be examined as part of continuing reviews of drug coverage for seniors.

High cost drugs in continuing care centres

Under payment plans in place in the early 1990s, nursing homes and auxiliary hospitals receive a flat fee of $1.88 per bed per day to cover the cost of drugs for their residents. High cost drugs were reimbursed based on actual expenditures. With the move to population-based funding, regional health authorities now are responsible for supporting the costs of drugs in facilities. Regional health authorities are expected to provide services that meet the residents' needs, meet certain expectations, provide sound management and efficient use of resources, set up a mechanism to ensure adequate and timely compensation for pharmacies, and develop a peer review process to ensure effective drug use.

The Committee understands that with increasing costs of medications, it is becoming more difficult to manage with the resources available.

"No other sector within the health care system is expected to provide drug therapy to frail seniors, often with multiple and interacting medical problems, at the level of continuing care centres. While a 'high cost drug supplement' was factored into budgets a year ago, the net allocation per resident ... is still inadequate."

Alberta Medical Association

Recommendation 37:
Address the high cost of drugs provided in continuing care centres

The Committee recommends that:

- *Additional funds should be provided to address shortfalls in funds available for high cost drugs in continuing care centres and to address issues related to utilization of new drugs, reporting and information needs, and a peer review process.*
- *Individuals who are assessed and require admission to continuing care centres should not be refused admission because of the cost of the medications they require.*
- *The distribution of funding for high cost drugs should be equitable and consistent for all continuing care centre operators across the province.*

Medication use by seniors

Appropriate use of medications is an important part of seniors' health. As noted earlier in this report, both the amount and the number of different medications that seniors are taking is a concern. If we are able to optimize drug use and control costs, patient care will be improved and resources would be available to provide coverage for new drugs and therapies when they become available.

Recommendation 38: Take steps to address appropriate use of medications by older people

The Committee recommends that:

- *A conference should be held in Alberta to initiate activities and begin developing solutions to ensure appropriate drug use by older people.*

- *Following the conference, specific strategies should be implemented to address appropriate drug use by seniors. Those strategies should include effective ways for physicians, pharmacists, nurses and health care providers to work together to regularly review and monitor prescriptions provided to individual seniors.*

Comments:

Appropriate drug use is an issue not just for Alberta but for other provinces and countries around the world. A conference early in 2000-01 could bring together experts, health professionals, seniors, health authorities, and other groups and agencies to address this issue. Technology should be used to provide opportunities for people to participate in the conference even if they are unable to attend. The conference should be viewed as a catalyst for action, bringing together experts from across the country and from other countries to address the issues and propose solutions.

Following the conference, specific strategies should be developed and implemented. A number of strategies could be considered. Work already underway through the Drug Utilization Review, jointly chaired by the Alberta Medical Association and the Alberta Pharmaceutical Association, should be supported. Strategies should be in place so that the kind and number of prescriptions provided to individual seniors can be regularly reviewed and monitored by physicians and pharmacists. In addition, opportunities to expand **alberta wellnet** to use technology to share

information and track medication use should be explored. The Committee also suggests that education for physicians, seniors and their family members is needed to reinforce the view that aging does not necessarily mean more drugs are needed.

Support for equipment and supplies

Recommendation 39:
Provide support for equipment and supplies

The Committee recommends that:

- *Individuals who receive care in the community for an acute care episode should have access to the equipment and supplies that are necessary for their treatment and recovery.*
- *For necessary equipment - people discharged from an acute care hospital should be provided with the equipment they need to complete their recovery from an illness or injury*
- *For medical and surgical supplies - people discharged from an acute care hospital should be provided with adequate and appropriate medical and surgical supplies to enable them to remain in their home. These supplies should be provided for as long as they are assessed as needed.*

Comments:

Policies on equipment and medical supplies should be consistent whether the individual is being treated in hospital or at home. If people have to pay for these supplies, there is a disincentive for them to be discharged from hospital. A health professional should be responsible for determining whether the equipment is needed. In most cases, equipment should be provided on a loaned basis. Regional health authorities and Alberta Aids to Daily Living should work together to ensure that there are not gaps in access to equipment.

Education and training

With an aging population, there will be increasing expectations for health professionals, providers and continuing care staff to have the specialized education and training to allow them to meet the needs of elderly people. Scattered throughout this report, there are frequent references to the need for expanded education – both as part of the initial preparation of health professionals and on an ongoing basis – to ensure that the unique needs of the elderly can be addressed.

The elderly population, particularly those in the older age groups, has unique health needs. These needs are often not well understood and, too frequently, they are not given enough attention by many health care professionals. The result is that health professionals may lack the skills and knowledge necessary to provide the best care for the elderly.

Specialized education that provides a high level of knowledge and skill in seniors' health, gerontology and geriatric medicine is required to meet needs of increasing numbers of elderly people in the community. Clearly, geriatric medicine is a growth area, particularly in rural areas, in communities, and in continuing care centres.

Combined with the need to expand education and training, steps also need to be taken to ensure that there is an adequate supply of health professionals – physicians and registered nurses in particular. While the number of physicians practicing in Alberta increased in 1998-99, there continues to be a serious shortage of physicians trained in geriatrics. Programs also are needed to expand the ability of family physicians to get additional training in geriatric medicine.

Currently, there is a shortage of registered nurses in specialty areas and that shortage is expected to continue over the next few years. Actions are needed to increase the enrolment in nursing programs, and to enhance courses and programs in geriatrics and training for nurse practitioners specializing in

"Nurses in long term care describe and believe their practice is a specialty area in the health care system ... In some situations, nurse practitioners could be providing health care services to meet the distinct needs of the elderly in the long term care setting."

Alberta Association of Registered Nurses

geriatric care. Currently, the only option for registered nurses who want to expand their training in geriatrics is to go on to master's level programs. These programs prepare them for supervisory and management positions, and tend to take them out of direct care for patients. In addition, there are few ways of recognizing and supporting nurse specialists who choose to remain in positions providing direct care to patients.

Today, the majority of geriatricians are found in acute care settings. However, the shift to community based care means that more professional care is needed in the home and community. There also has to be a strong support system to provide people with the assistance they need to manage in their homes. Non-professional staff generally provide assistance with activities of daily living and the support people need to remain in their homes.

At the same time, the health needs of people in the home and community are changing. Many people residing in the community have complex health care requirements. There are no basic standards of skill and knowledge that community care support workers must meet in order to provide care to groups with very diverse needs, e.g. the frail elderly, the disabled, those with brain injuries, mental health problems, dementias and chronic health conditions.

Combined with the lack of standards for basic skills and competencies, continuing care staff also face particular challenges. The importance of their work is often undervalued. Their pay levels are not high. Opportunities for training and expanding their skills are often minimal, and when provided, offer no official (certification or diploma) acknowledgement that may be used for purposes of work advancement. Not surprisingly, attraction and retention of support workers is problematic in many regions. Providing opportunities for skill and knowledge enhancement may help to lessen this issue through improved job satisfaction and possible work advancement.

Recommendation 40: Expand education and training for professionals and non-professionals

The Committee recommends that:

- *All health care workers – professionals and non-professionals – should have the appropriate skills and knowledge to respond to the needs of an aging population.*
  - *To achieve that objective, the following steps should be taken:*
    - *Courses and programs in geriatrics should be expanded to include more courses in geriatrics at the graduate and undergraduate level.*
    - *Geriatric training should be included as part of the mandatory curriculum for health professionals.*
    - *Alberta Health and Wellness, in cooperation with other departments, should provide stand alone, Ministry-based funded positions for training in geriatric medicine to be shared equally between the province's medical schools.*
    - *Ongoing training and inservice should be provided through lectures, workshops, seminars, on-site training courses and certificate programs.*
    - *Affordable home study courses should be available for support staff in facilities and community care.*
- *The number of nurse specialists in geriatrics should be increased. Current barriers to expanding the supply of nurse specialists in geriatrics should be identified and removed.*
- *Regional health authorities should have sufficient funds available to allow them to support the costs of ongoing education and training opportunities in seniors' health and geriatric medicine.*

"It is important to invest in your people. You can put the best structure in the world in place but if you don't have good people, it won't work. You need more geriatricians and to develop the expanded role of the clinical nurse specialist. It is important to focus on frailty and the geriatric multidisciplinary team."

Dr. Ken Rockwood, Professor of Medicine, Dalhousie University

"We in Alberta have the opportunity to plan for the graying of our society. The multifaceted response to this challenge should include addressing the place, purpose, and status of geriatric medicine."

Dr. David Hogan,
Professor, Faculty of Medicine,
University of Calgary

Comments:

As noted throughout this report, there is a serious need for expanded education and training opportunities for health care providers working with seniors. Alberta currently has a shortage of people trained in geriatric medicine and, as a result, geriatric assessment services are available primarily only in larger centres. With an aging population, understanding the complex, chronic health needs of the frail elderly will be increasingly important.

The Committee believes that not only should there be expanded opportunities for specialization within the education programs for physicians, registered nurses and other health providers, but also that all health providers should be required to have some basic understanding and knowledge of seniors' health and geriatric care as part of their training. Ongoing inservice education is essential and should be provided by regional health authorities in cooperation with post-secondary institutions and other agencies. The Committee sees an increasing opportunity for these programs to be delivered using technology and other distance learning approaches so that people can access the programs from their own homes.

The Committee also recommends that specific, designated positions should be funded in Alberta's medical schools to ensure there are sufficient places available to expand the number of geriatricians in the province.

Recommendation 41: Establish basic standards for continuing care staff

The Committee recommends that:

- *Basic standards and competencies should be developed for continuing care non-professional staff who work in public, private or volunteer continuing care agencies, home care or continuing care centres. Once the standards are in place, non-professional staff should be expected to meet those standards within a set amount of time. Alberta Health and Wellness should work with Alberta Learning, health authorities and other key stakeholders to develop appropriate standards and competencies.*

Comments:

Currently, there are no consistent standards for non-professional staff who work in continuing care centres, for agencies, or provide home care. With the growth in home care, community care workers are expected to provide home care to people with high health care needs. In view of the increasing complexity of care needed by people both at home and in facilities, it is important for standards to be set and for staff to have opportunities for appropriate training and upgrading. Establishing standards will also help to increase recognition for the important work these people do.

"Without the support of a trained and skilled workforce, with an appropriate level of professional training, many initiatives designed to improve the quality of care will be unable to get off the ground."

From public consultations

Recommendation 42: Establish a province-wide program in seniors health and geriatric care

The Committee recommends that:

- *A provincial Network of Excellence in seniors' health and geriatric care should be established to provide leadership and innovation, education and training, and research.*

Comments:

A number of concerns have been expressed about the need for enhancing professional education in seniors' health and geriatric care, and expanding opportunities for continuing education. The Committee understands that steps have been taken at the University of Alberta, for example, to establish a Centre of Gerontology. The Education Resource Centre for Continuing Care used to be a province-wide program but, with regionalization, it has become part of the Calgary Regional Health Authority.

There currently is no province-wide program that serves the entire province and can act as a virtual centre with links to communities across the province. The Committee felt that a higher profile provincial Network of Excellence would not only expand opportunities for education and training but also provide a catalyst for ongoing innovation, leadership, and research. The Network could develop inservice education in cooperation with existing post-secondary institutions, make expanded use of technology to deliver programs, and support ongoing targeted research in gerontology. Regional health authorities and other organizations would be able to access the provincial program, particularly for inservice education.

Recommendation 43: Ensure an adequate supply of health care professionals and other providers to work with an aging population

The Committee recommends that:

- *Steps should be taken to assess, review and forecast the number and types of health professionals required to best meet the needs of an aging population. Strategies also should be developed to retain and ensure that sufficient numbers of geriatricians and registered nurses are available in the province.*

- *To address shortages of trained staff in continuing care centres and in home care services, strategies should be developed to ensure that there is an adequate supply of trained community care workers.*

Comments:

It is important that Alberta has an adequate supply of well-trained health professionals and workers to meet the needs of an aging population. Projections are needed to help in planning for health workforce in the future. A variety of strategies are needed to attract and retain geriatricians and nurses with specialized skills, including special incentives where necessary.

The Committee recommends a major expansion of the programs and support at home and in the community. Strategies need to be in place to ensure that there is an adequate supply of trained non-professional staff to work in community and home care programs and in continuing care centres.

Both of these issues should be addressed as part of ongoing work in Alberta Health and Wellness to address future workforce needs.

"We can easily come to believe that most seniors requiring care are receiving it from the formal system ... We need to frequently remind ourselves that this is false. ... 70 – 80% of the personal care for seniors is provided by informal caregivers, usually a spouse or a daughter."

Nancy Gnaedinger, Consultant in Gerontology, Victoria, B.C.

Recognizing the role of informal caregivers

In Canada, 80 to 90% of home care is delivered by an informal caregiver in the home. One in five Canadian women between the ages of 30 and 55 provides care to someone in the home who is either chronically ill or disabled and spends an average of about 28 hours a week in that work. About half of those women also work outside the home and many have dependent children. Many informal caregivers are elderly spouses whose health will be compromised over time with the stress of providing care to their partner.

Informal caregiving responsibilities can range from "helping out" (i.e. doing errands, assisting with yard/house work, taxes, etc.) to providing daily care for a severely disabled relative.

Higher levels of stress for informal caregivers have been shown to be related to the greater number of personal care dependencies, symptoms of mental impairment and, especially, disruptive or "acting out" behaviors of the care recipient. "Burn out" and frustration are not uncommon among informal caregivers. Training and support groups that teach coping skills to informal caregivers and provide flexible amounts of respite care have been shown to be effective in reducing the amount of stress felt by informal caregivers.

Research suggests that informal caregivers prefer direct-service programs to either cash payments or tax allowances. However, tax allowances are seen by informal caregivers as government recognition of the importance of the contributions they make.

Within the health system, informal caregivers are often not seen as an integral part of care planning. Clients are assessed through a formal system that often does not include input from informal caregivers.

Recommendation 44: Support informal caregivers

The Committee recommends that:

- *Health authorities should develop strategies to ensure that informal caregivers are appropriately involved as part of "the team" in assessing and managing an individual's needs and services.*
- *Alberta Health and Wellness should work with health authorities to explore appropriate strategies for supporting informal caregivers.*
- *Employers should be encouraged to provide flexible policies that allow staff to act as caregivers for relatives.*

> *"Informal caregivers must be not only recognized but also supported, both through empowerment mechanisms as well as through an adequate community support system."*
>
> *Dr. Neena Chappell, Director, Centre of Aging, University of Victoria*

Comments:

While the Committee is not in a position to make specific recommendations on the most appropriate ways of supporting informal caregivers, we do recognize the important role they play. We encourage regional health authorities to involve informal caregivers as much as possible in decisions about a client's needs and the type of care to be provided. In terms of support for informal caregivers, consideration should be given to a variety of options including:

- enhancing programs such as respite care and day programs
- providing information
- providing educational materials
- providing linkages to volunteer support groups
- enhancing publicly funded professional and support services, including self-managed and guardian-managed care.

As noted above, often caregivers are also actively involved in the workforce and it becomes difficult to juggle work responsibilities and responsibilities to elderly parents and

loved ones. Flexible policies to allow unpaid leave for as little as a day or two, or up to several months, without losing pensions or other benefits should be considered by government and other employers as important steps in recognizing the role of informal caregivers.

Respite care

As noted above, informal caregivers play a very important role in providing ongoing care for family members and friends. Respite care, provided in continuing care centres or in other settings, provides temporary relief for informal caregivers, giving them a break to look after their own needs or simply to take time off from caring for family members or friends. It is one of the most important ways to prevent "burnout" in caregivers.

There are different types of respite care available depending on the assessed needs of the individual. Respite care could involve day programs, night programs, adult day care, or other options.

Specific recommendations on expanding the availability of respite programs are provided in other sections of the Committee's report. Specifically, we recommend that respite programs should be available in continuing care centres as part of an expanded role for the future. We recommend that people receiving respite care should be charged for the accommodation costs of the services they receive, but should not pay a portion of the capital costs, primarily because they are already maintaining a residence. We also recommend that additional support should be available for informal caregivers in the form of education, linkages to volunteer agencies, and support from other professionals.

Recommendation 45:
Expand respite care

The Committee recommends that:

- *Alberta Health and Wellness, in collaboration with the regional health authorities, should review the number of beds required for respite care in each region. The capital housing costs for respite beds should be fully funded by the province.*

Ethical issues

Ethical issues are not explicitly within the mandate of the Committee but they certainly were raised during the public consultations. The Committee understands that ethical issues will become increasingly complex and important with an aging population.

Life expectancy is increasing and, compared to people in other provinces, Albertans are expected to live long and healthy lives. Medical technology and new advances in medical treatment can extend life for many people. As the population ages, more complex medical conditions will be encountered. Ethical issues such as quality of life and informed choices are gaining increasing importance.

In terms of the health system, and particularly for seniors' health and continuing care, the key ethical issues relate to:

- Promoting autonomy for seniors and their right to make their own decisions but, at the same time, taking into account their decision making capacity and the role of others, especially family members, in helping with important decisions
- Preserving quality of life and personal dignity
- Making decisions about end of life therapies
- Making decisions about treatment and therapies especially near the end of life.

- Sorting out the roles of individuals, family, informal care givers, health providers and government in supporting programs for the elderly.

On an individual level, preserving and promoting personal dignity and autonomy for the elderly is a crucial ethical imperative. Autonomy and choice are more difficult to achieve in institutional settings where practical considerations can put constraints on a person's ability to make choices. Decisions about how to encourage and support individual choice and capacity for choice, protect the vulnerable from abuse and mistreatment, and limit the erosion of privacy and control, all involve important ethical questions. The most frequent ethical dilemmas involve:

- deciding whether a person is capable of making their own decisions
- the use of guardianship and personal directives, providing decision-making powers to family, loved ones and care providers
- making decisions about appropriate treatments including tube feeding and providing nutrition and hydration, infection control, restraint use and resuscitation. Questions about end of life treatment are particularly problematic.

At the community and societal level, key ethical questions involve:

- the roles and responsibilities of family, informal caregivers and government in supporting programs and services
- balancing the need to treat the elderly with the highest level of care that is possible and appropriate while, at the same time, keeping in mind the limitations of available resources and the need for health care to be available to everyone who needs it
- respecting the various attitudes, cultures and beliefs, as well as changing family patterns
- shifting societal attitudes toward aging and end of life
- balancing the virtually exponential growth of medical technology with quality of life issues.

Many of these ethical issues were raised through the public consultations. Specifically, there were suggestions to increase the knowledge of personal directives, streamline the process to access guardianship and trusteeship, and address end of life decisions and the implications for health policy. Older people fear they will be denied treatment because of their age, and some also fear that they will not get appropriate palliative care, especially in managing pain.

Across Canada, many are saying there needs to be an open, public debate and discussion of ethical issues in health, particularly related to end of life treatments.

Recommendation 46:
Take steps to explore ethical issues

The Committee recommends that:

- *A multidisciplinary provincial forum should be established to:*
  - *Explore ethical issues specific to seniors' health*
  - *Regularly communicate positions and policy advice on ethical decision making to assist the health system and continuing care providers in making decisions, delivering programs, and to establish appropriate policy.*

- *Existing resources such as the Provincial Health Ethics Network should be more fully utilized to address ethical issues in continuing care across the province.*

- *Current payment mechanisms and subsidies should be reviewed to ensure that they reflect the principles of fairness and equity, compassion and respect for the dignity of individuals, and affordability for individuals, government and society.*

- *Government should continue to provide information and education about personal directives.*

Comments:

Many of the ethical issues are not unique to a particular regional health authority. Resources to address these issues are often difficult to access. A coordinated provincial strategy to address these issues will reduce duplication of effort, promote a cooperative approach, encourage consistency across regional health authorities and institutions, reduce disparities in accessing ethics resources between rural and urban communities, and stimulate wider analysis and discussion of pressing ethical issues in continuing care.

Resources such as the Provincial Health Ethics Network provide support for individuals and groups interested in exploring difficult health ethics issues. The Network can be used to: facilitate ongoing education of care providers, administrators and other decision makers; maintain a data base of policies to be shared across the system; identify people with expertise in ethics to assist in addressing local issues; and provide support to new or existing local groups mandated to address ethical decision-making and resolution of disputes. These services would be made available to regional health authorities and a wide range of groups and agencies.

How continuing care services and facilities are funded and the types of subsidies that are available can have a direct impact on the ability of individuals to make choices. Government departments should review the current payments and subsidies to ensure they are consistent with the principles noted above. Any changes in funding and subsidies should take into account the impact they have individuals and their ability to maintain their independence and dignity. This issue should also be addressed by the Government-Wide Study of the Impact of the Aging Population.

The Committee also heard concerns from the public about the need to expand information available to seniors. Documents such as *Choosing now for the future*, produced by Alberta Health and Wellness, provide useful information about personal directives. This information should be widely available to seniors and their family members. It contains

important information about the value of personal directives in allowing people to appoint a guardian to make decisions on their behalf. Efforts have been made both by Alberta Health and Wellness and the regional health authorities to make this information available. The Committee suggests that Alberta Health and Wellness work with Alberta Community Development, regional health authorities and other groups and agencies to expand awareness of this information. Regular communications vehicles directed at seniors including newsletters, inserts and web sites should be used wherever possible.

Research and innovation

Seniors' health is important today, and it will be increasingly important as our population ages. Continuing care now is the third largest sector of health services. About 44% of the total health care budget goes to service people over 65. There are opportunities to manage those resource effectively, to keep people healthy and well, and to organize services in the most efficient and effective ways. But that requires ongoing research, innovation and evaluation to determine what works well and what doesn't.

Currently, between $600 and $700 million is being spent each year on continuing care, but there is insufficient research underway.

"Personal directives can have a positive impact on health care costs and can influence the type and intensity of care provided to seniors. Yet few Albertans are aware of this new act and its implications; nor do Albertans recognize that personal directives should be developed when they're well, not ill. Public education and appropriate intervention are needed. This is a pressing issue for physicians."

Alberta Medical Association

"My own beliefs about designing care for the elderly into the millennium include:
- It is not possible to deal effectively with the future needs of caring for the aged population with a single plan or one approach or policy, but rather an integrated set of policies
- We must have the courage to alter the course and permit our innovative projects to take us in new directions
- Housing and personal care must be unbundled and re-bundled, but not fumbled."

Phil Gaudet, President, Canadian Home Care Association

Recommendation 47: Expand research on aging and continuing care

The Committee recommends that:

- *Funds should be available to support ongoing research on aging and continuing care, as well as to develop and implement innovative programs and service delivery models.*
- *Information about successful new models, alternative service delivery, best practices in other provinces and countries, and research findings should be shared widely across the health system and with the public.*
- *Within three to five years, the provincial government should undertake a comprehensive review of progress in implementing the recommendations of this Committee and the impact on seniors' health and continuing care services.*
- *Specific funding should be set aside in Alberta Health and Wellness for this review.*

Comments:

A new continuing care system can't be built without research, innovation and evaluation. Ongoing research and innovation in continuing care is essential to respond to the changing needs of an aging population. Funding should be in place to encourage innovation and new approaches to providing continuing care. A pool of funds could be used to support province-wide projects such as developing information technology systems, outcome measures, inservice and professional development activities, and innovative care delivery programs. Information about best care practices should be regularly compiled and shared widely across the system. Research should focus on developing data bases, tracking and evaluating new models, and monitoring and evaluating trends in healthy aging, disabilities and chronic conditions in seniors.

A Health Innovation Fund has already been developed by Alberta Health and Wellness. Support could be provided from the fund to support priority projects in:

- Alternative models of care delivery for clients with dementia
- Supporting care provided in supportive living arrangements
- Exploring new ways of delivering home care.

The Committee also recommends that the impact of its report and recommendations should be reviewed within three to five years. The Committee has set a bold new vision. Many of its recommendations will result in significant change in how the system operates to serve the needs of an aging population. Within five years, much can, and undoubtedly will, change. It is important to take stock, assess where good progress has been made, consider whether the vision and direction continue to be right for Alberta, and make changes wherever necessary. Specific funding should be set aside for this purpose.

Information and technology

Like all sectors of the economy, technology is having a significant impact on the health system. New technologies not only change the way services are delivered, but can also be used to expand access to information, streamline services, and provide support for people so they can stay independent and in their own homes. While the focus is on the potential of technology and the what it can do, it is important to also remember that health is and will always be a "people" business, with the first focus being on providing thoughtful and appropriate care to meet people's needs.

Technology will be important in the following ways:

- **In helping people stay in their own homes** – Advances in technology such as lifeline systems, monitoring and interactive video systems, combined with less invasive surgeries and joint replacements, can help people live

independently for longer. Telehealth can be used to facilitate home care and other types of diagnosis and treatment in remote parts of the province. While technology can help in these areas, it is no substitute for direct contact in combating loneliness, helplessness and boredom in seniors.

- **In improving the management of the system** - Information systems can be used for planning, facilitating, managing resources and for automated record keeping systems. It is important to have consistent standards across the province so that comparable information can be accessed and privacy protected.

- **In improving diagnostic and therapeutic services** – New advances in technologies are helping physicians and other health providers diagnose health problems and providing leading edge treatments. New systems being developed by **alberta wel*l*net** will provide access to seniors' drug profiles in emergency rooms and help prevent serious drug interactions.

- **In keeping people well informed** – Computer technology, especially the Internet, provides a useful way for individuals to access vast amounts of information about their own health and services available to them. Seniors are increasingly using the Internet as a way to get information about health and health services.

While the Committee does not have any specific recommendations regarding technology, we believe that, if used appropriately, technology has the potential to improve services and help older people maintain their independence. At the same time, decisions on expanding the use of medical technology should consider their impact on the quality of personal care that people receive, as well as cost effectiveness and the ethical impact technology may have on people's quality of life.

Transportation and ambulance services

As the population ages, it won't be good enough simply to offer quality health services in the community. People will need help getting to and from those services, and participating in community programs. Transportation becomes a health issue when people need access to health programs and services. In these cases, it is appropriate that transportation services should be considered a shared responsibility.

Accessible transportation to necessary health services is vitally important whether people are living at home, in supportive housing arrangements or in a continuing care centre. People may also need someone to accompany them and provide assistance when they travel to programs and services. Transportation should be by the most appropriate and cost effective mode, and should involve ambulances only when it's medically necessary.

Volunteers play a very valued role in providing transportation for those in need. However, liability issues have become a major concern and need to be addressed. The Committee understands that liability is assumed by whoever owns the vehicle. If volunteers are transporting people in a vehicle owned by a regional health authority or an operator of a facility, the liability is not their responsibility. But they are responsible if they are transporting people in their own vehicle.

Regional health authorities should be responsible for coordinating transportation to health services they provide and for ensuring that there are linkages in place to other community agencies providing social supports and other services.

According to current policy, people who are receiving self-managed care funds are not supposed to use those funds for transportation costs, although there are different interpretations of this policy and inconsistencies across different regions.

The Committee also heard that there are inconsistencies in ambulance services and policies across the province.

Recommendation 48:
Clarify responsibility for health-related transportation

The Committee recommends that:

- *Steps should be taken by the provincial government to sort out responsibility for a variety of health-related transportation issues, including ambulance services.*

Comments:

There continue to be inconsistencies in health-related transportation policies across the various regional health authorities and municipalities. Responsibility for and consistency across the various aspects of health-related transportation need to be clarified. The following components should be addressed:

- Transportation to and from hospitals
- Transportation between continuing care centres
- Transportation between continuing care centres and acute care hospitals
- Transportation to and from medical treatment and testing services, and to and from services that are instrumental to daily living, including resolving the issue of liability
- Transportation to and from day programs.

In relation to ambulance services, the Committee understands that considerable work has been done in the past to review ambulance services across the province. The Committee encourages Alberta Health and Wellness to continue to review accessibility of ambulance services across the province and to take steps to implement the recommendations suggested in earlier reports.

With an aging population, it will be increasingly important to have consistent and clear policies for health-related transportation across the province. While the Committee is not in a position to provide specific solutions, we strongly encourage the government to work with regional health authorities and municipalities to sort out responsibilities, and develop consistent policies across the province.

Addressing accountability and standards

Addressing accountability

Accountability is defined as "the obligation to answer for the execution of one's assigned responsibilities to the person or group who conferred the responsibilities." (*Achieving Accountability in Alberta's Health System*, November 1998)

To have appropriate accountability, it is important to sort out who is responsible for what, determine what outcomes are expected, decide how those outcomes will be measured, allocate sufficient resources to get the job done, review and assess the outcomes achieved, then take follow up actions to improve performance on a continuing basis.

Accountability is important in the health system and for continuing care services. For individuals and their families, it is sometimes difficult to understand the various roles and responsibilities, what standards are expected, or where to go if they have concerns.

Alberta Health and Wellness has done considerable work in clarifying accountability in the health system. *Achieving Accountability in Alberta's Health System* describes the various roles and responsibilities of the Minister of Health and Wellness, regional health authorities, health professionals and a variety of other organizations.

The Committee's recommendations for new legislation suggest that the various roles and responsibilities in continuing care should be clarified, standards should be set, and there should be a clear mechanism for monitoring quality of care. These recommendations are important ways of ensuring that there is appropriate accountability in the system.

Recommendation 49:
Establish clear lines of accountability

The Committee recommends that:

- *The current work of Alberta Health and Wellness in clarifying accountability should be endorsed and supported.*
- *As noted in the recommendations regarding future legislation, a new Continuing Care Act should clarify the roles and responsibilities of the various organizations involved in continuing care, ensure that consistent standards are in place, and establish a clear mechanism for monitoring the quality of care provided throughout the continuing care system.*
- *As noted in recommendations related to funding mechanisms, a core set of provincial outcome measures should be developed for continuing care. Regional health authorities should report on those measures as part of their annual reporting requirements.*

Comments:

The Committee endorses the work already underway in Alberta Health and Wellness to clarify accountability relationships and set clear expectations for the health system. This work should serve as a framework for continuing care. As noted in earlier sections, the Committee recommends that a new *Continuing Care Act* should be developed. Accountability relationships, standards and expectations should be established as part of that process.

A key part of accountability is the responsibility to assess outcomes and report on what is being achieved. By establishing a core set of measures along with regular reporting requirements for regional health authorities, we will be able to track progress, assess whether the results are what we want and expect, and take action where necessary to improve results.

Setting and maintaining standards

To maintain and continuously improve the quality of care provided, it is important for some key elements to be in place. As noted above, clear expectations and lines of accountability are essential. Standards must be in place, backed up by legislation and by effective ways of monitoring programs, services and facilities to ensure that standards are being met. Performance measures should track progress and results, and point to areas where improvements are needed. And finally, every individual health professional, health care provider, organization and facility must have a commitment to quality care and a strong desire to provide caring, compassionate and excellent quality services.

A number of those components are in place today. Certainly, health care providers and professionals are committed to providing the best care possible. Steps have been taken to clarify roles, responsibilities and accountability. The business plans of Alberta Health and Wellness and the regional health authorities set out the goals and objectives they expect to achieve along with performance measures. Each year, both report on the results they actually achieved. Work also has been done within Alberta Health and Wellness to set out expectations regional health authorities are expected to meet. However, as noted in earlier parts of this report, there are areas where more work is needed.

Currently, Alberta has multiple continuing care facilities with varying regulations and standards of care. This makes it difficult to assess overall performance of services. Regional authorities contract services with private and volunteer agencies, and contracts set out the expected standards of care

"...accountability within the health care system should not be limited to financial accountability but should extend to accountability for professional competence, legal and ethical conduct, adequacy of resources, public health promotion and community benefit."

From public consultations

to be provided. However, these standards are not necessarily consistent across the province. In a number of places, there are no clear standards that have been set or legislative authority to monitor and evaluate to ensure that standards are being met.

Recommendation 50:
Set standards and monitor outcomes

The Committee recommends that:

- *Measurable program standards consistent with the overall direction of this report should be developed and implemented by Alberta Health and Wellness and regional health authorities.*
- *These standards should be included in the contracts that regional health authorities have with private and volunteer agencies and facilities.*
- *The current monitoring and evaluation mechanisms should be reviewed and enhanced on a continuing basis to ensure that standards are being met, and quality of care is appropriate and consistent across the province. Alberta Health and Wellness should lead this review in cooperation with regional health authorities.*
- *As noted in earlier recommendations, a new Continuing Care Act should establish policies and standards for care. A core set of measures should also be established, and performance should be tracked on a continuing basis.*

Next steps

The Committee would like to thank everyone who participated in the review of long term care in the province and helped us set a new direction for the future. Literally hundreds of Albertans, including seniors, health care providers, health authorities, experts and organizations took time to consider today's issues and offer their ideas for the future. Their advice was instrumental in shaping the views of the Committee as it set about the task of developing recommendations.

We have learned a great deal about Alberta's health system and the people who work in the system day after day to meet people's health needs. The quality of care people receive today depends directly on the dedication and commitment of outstanding family physicians, specialists, nurses, and a whole range of people who work in home care, in long term care centres, in hospitals, in seniors' housing and in other community programs. Our recommendations are intended to build on and support the important work these people do.

We believe that a combined focus on healthy aging, new directions for care and different housing options will provide the kind of balanced and forward looking approach Alberta needs to prepare for the next generation of older people.

Success will follow if ...

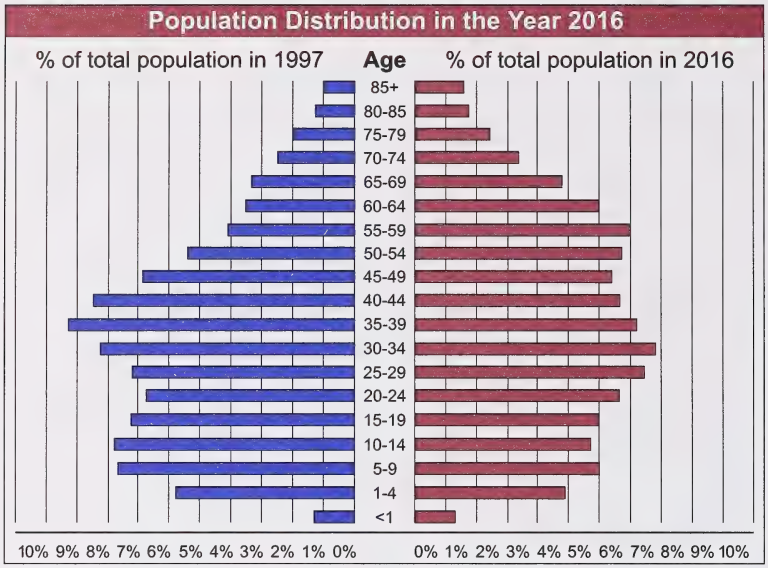
- deliberate steps are taken to implement the package of recommendations included in this report
- those in the health system are able to manage care effectively and make the best use of available resources, programs, services and facilities
- sufficient resources – people and money – are in place there is a spirit of cooperation among people working in the health system
- Albertans embrace a new vision for healthy aging and continuing care and take steps to make that vision a reality.

We encourage the government and all Albertans to act quickly – in collaboration with seniors, physicians, nurses, health care providers, and health authorities – to set a new course for the future of seniors' health and continuing care in the province.

Appendix 1

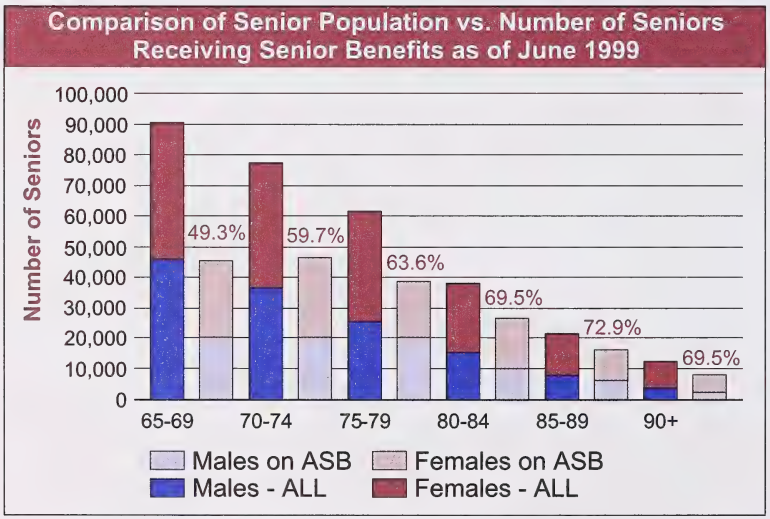
Selected figures and tables

Figure 5



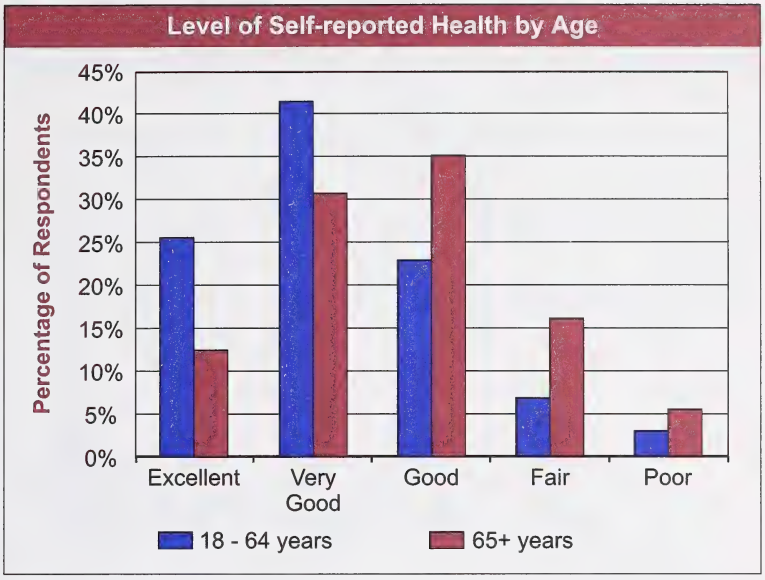
Source: Alberta Population Projections, graph developed by KPMG.

Figure 6



Sources: Alberta Treasury. Median Population Projections 1995 - 2011
Statistics Canada: Growth Rate of Alberta Population Projections #4-2012-2016
Alberta Service Benefits Program

Figure 7



Source: The Alberta Centre for Health Services Utilization Research, June 1999

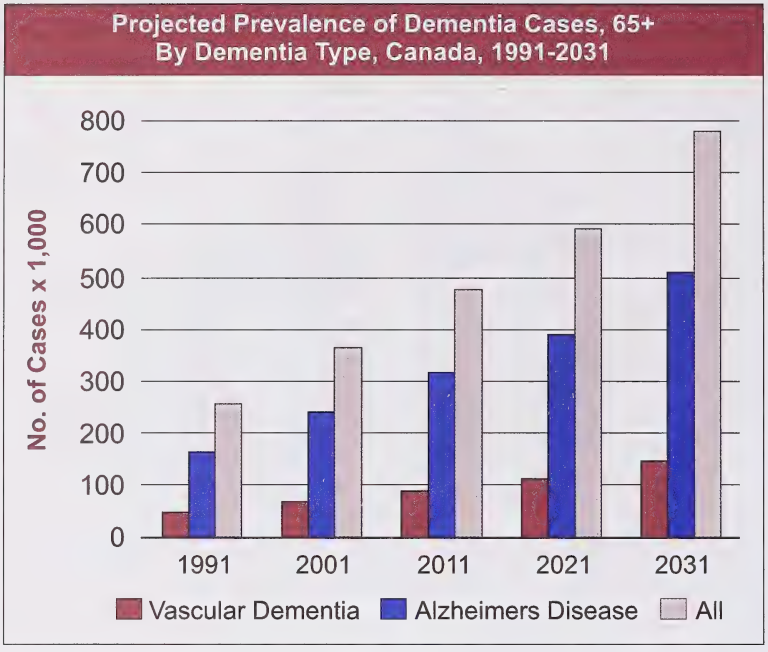
Table 2 (Appendix 1, Part Three - Age Distribution)

Estimated Number ('000) and Percentage of Dementia Cases (all types) in the 65+ Population, by Age, Gender and Residential Group, Canada, 1991

Age Group	Residence					
	Community		Institution		Total	
	Estimated # in 1000s	%	Estimated # in 1000s	%	Estimated # in 1000s	%
65-74	28.8	1.6	15.8	41.9	44.7	2.4
75-84	62.2	6.9	48.0	53.3	110.2	11.1
85+	32.9	17.8	64.9	66.0	97.7	34.5
All Ages	123.9	4.2	128.7	56.9	252.6	8.0

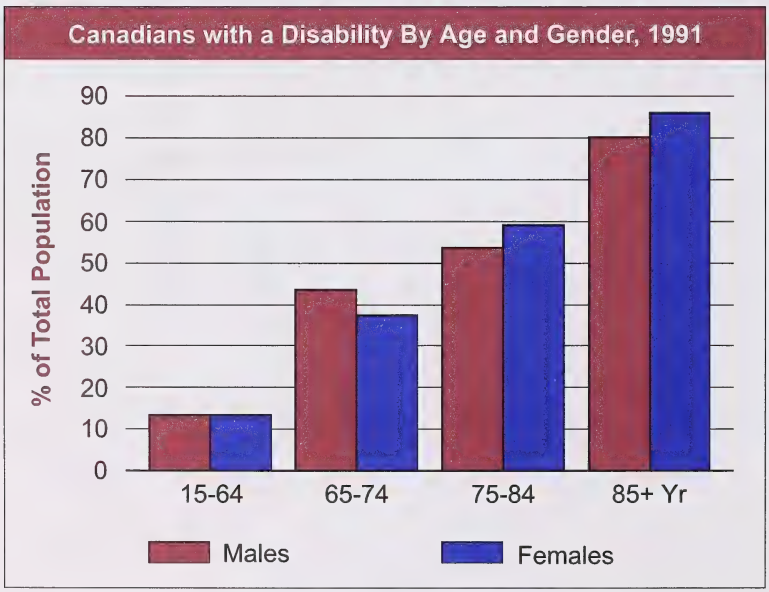
Source: "Canadian Study of Health and Aging: study methods and prevalence of dementia." *Canadian Medical Association Journal*. 1994; 150: 899-913.

Graph 8



Source: McMaster University, Gerontological Studies, 1996

Figure 9



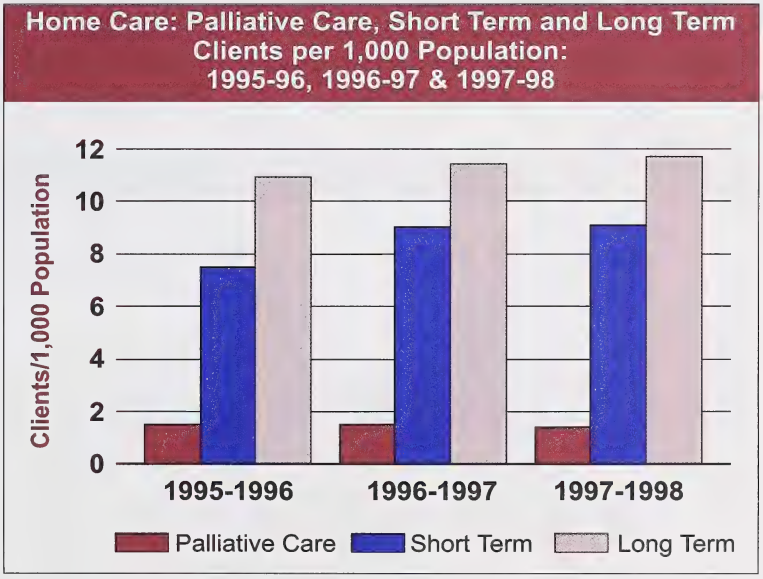
Source: Canadian Study of Health and Aging: study methods and prevalence of dementia. Canadian Medical Association Journal. 1994; 150: 899-913.

Table 3

Number of Clients Receiving Home Care Services in Alberta per 1,000 Population: 1992, 1994, 1996 & 1998				
	1992	1994	1996	1998
0 - 24 Years	1	2	3	3
25 - 64 Years	5	7	9	10
65 - 69 Years	50	54	61	61
70 - 74 Years	95	99	107	105
75 - 79 Years	168	175	161	178
80 - 84 Years	268	279	289	296
75+ Years	**244**	**259**	**273**	**282**
85+ Years	**350**	**384**	**431**	**465**

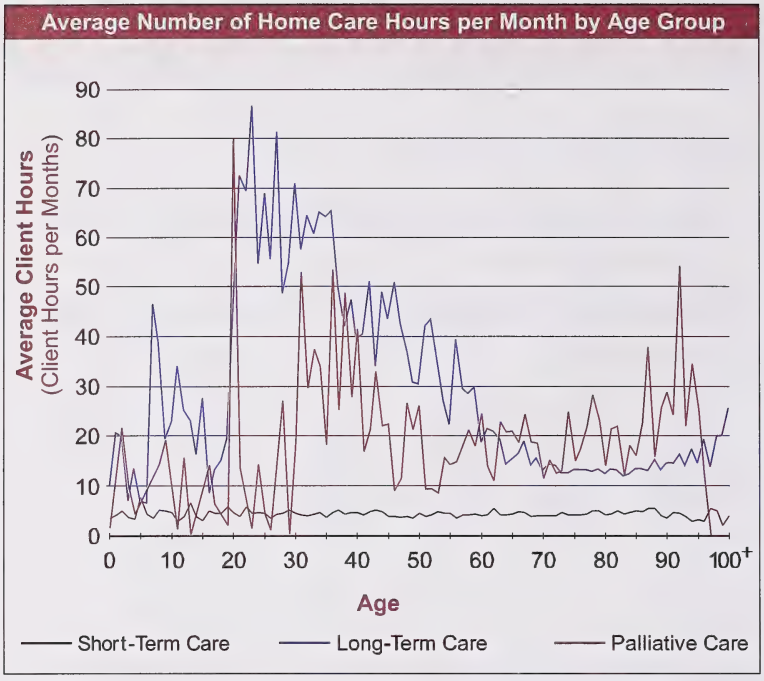
Source: Alberta Health, Alberta Health Care Registry
Alberta Health, Alberta Home Care Information System

Figure 10



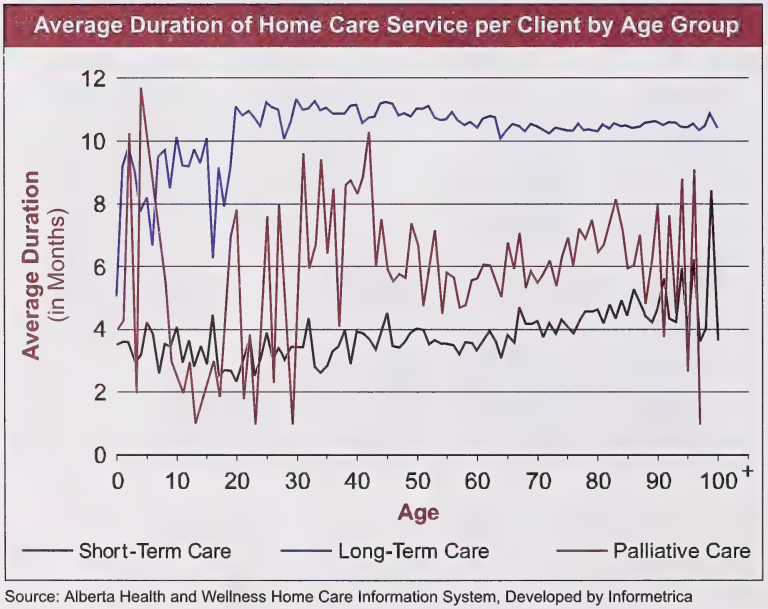
Source: Alberta Health Web Site - D1A - D4

Figure 11



Source: Alberta Health and Wellness Home Care Information System, Developed by Informetrica

Figure 12



Source: Alberta Health and Wellness Home Care Information System, Developed by Informetrica

Table 4

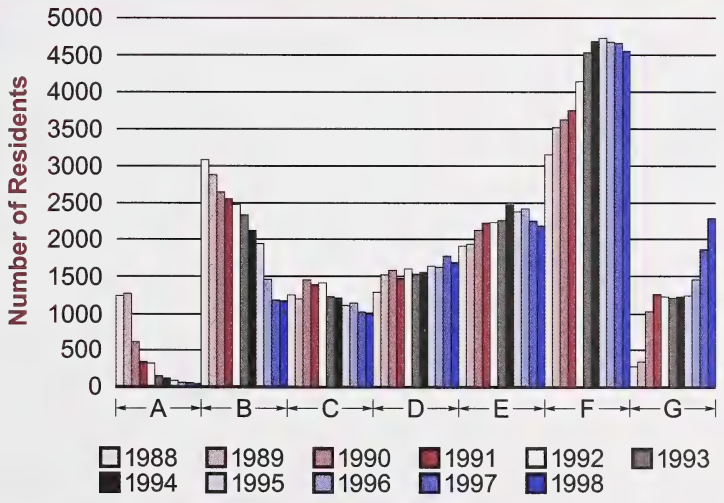
Number of Residents Living in Long Term Care Centres per 1,000 Population: 1989, 1992, 1994, 1996 & 1998

	1989	1992	1994	1996	1998
0 - 24 Years	0.03	0.03	0.02	0.01	0.01
25 - 64 Years	0.08	0.8	0.7	0.6	0.5
65 - 69 Years	9	8	8	7	6
70 - 74 Years	18	17	16	15	13
75 - 79 Years	41	38	38	34	32
80 - 84 Years	91	87	84	79	72
85+ Years	244	227	215	221	205

Source: Alberta Health, Alberta Health Care Registry
Alberta Resident Classification System

Figure 13

Alberta Resident Classification System Categories by Number of Residents: 1988-98



Source: Alberta Health, Alberta resident Classification System 1988-98

Table 5

Alberta Health 1997-98 Health Services Expenditures By Age Group ($'000)						
	Health Authorities	Practitioner Services	Non-Group Drugs	Aids to Daily Living	Other Programs	Total (1)
0-64 Years	$1,366,854 (52.2%)	$684,531 (75.8%)	$33,406 (17.1%)	$20,984 (39.2%)	$99,351 (75.8%)	$2,205,125 (56.5%)
65-74 Years	$350,448 (13.4%)	$112,608 (12.5%)	$91,772 (46.9%)	$16,890 (31.5%)	$16,344 (12.5%)	$588,062 (15.1%)
75-84 Years	$491,614 (18.8%)	$79,936 (8.9%)	$53,753 (27.5%)	$11,873 (22.2%)	$11,602 (8.9%)	$648,778 (16.6%)
85+ Years	$408,713 (15.6%)	$26,036 (2.9%)	$16,592 (8.5%)	$3,795 (7.1%)	$3,779 (2.9%)	$458,916 (11.8%)
Total	$2,617,630 (100%)	$903,11 (100%)	$195,524 (100%)	$53,542 (100%)	$131,075 (100%)	$3,900,882 (100%)

(1) One-time infrastructure/deficit assistance of $208,981,000 not included in the above total.
Source: Alberta Health Annual Report 1997-98

Appendix 2

Glossary of terms

Glossary of terms

Continuing Care System

Continuing care is a system of service delivery, which provides individuals who have health conditions or disabilities with access to services they need to experience independence and quality living. These services include professional services, personal care services and a range of other services. They may be provided for a short term or a long term. Usually these services are provided in long term care centres or in the home. There is an increasing trend toward providing services in a variety of settings.

The new terminology used to describe the location for continuing care services is two streams of services: community care and facility-based. The facility-based stream includes publicly funded continuing care centres such as nursing homes, auxiliary hospitals and other facility-based centers. The community care stream is further divided into the home living stream (single dwellings/apartments) and the supportive living stream (group homes, seniors' complexes, lodges/enhanced lodges and assisted living.

Long Term Care Centres

Traditionally, facility-based long term care services are provided by nursing homes and auxiliary hospitals known as long term care centres. Long term care centres provide a range of care services including professional services such as the necessary nursing services, personal services, life enrichment services as well as accommodation and meals.

Continuing Care Centres

Continuing care centres is the new terminology used to describe the new generation of nursing homes and long term care centers. They provide the traditional facility-based long term care services and can be sites for specialized services such as subacute, respite and palliative care services. Services for people with Alzheimer's disease and other dementias may also be provided in these settings.

Home Care

Home care services provide professional and support services to all Albertans who need these services to achieve and maintain health, well-being and personal independence in private dwellings. The services are provided based on assessed needs. These services have three components: long term home care, short term home care and palliative care. These services are also provided in supportive housing sites. These include professional services such as nursing, physiotherapy, occupational therapy, social case work, personal care services, homemaking services, and other professional services as required.

Supportive Housing

Supportive housing is defined as a way of providing an appropriate living environment for the frail and older adults who do not need the services of a residential care facility/ nursing home. It would include, at a minimum, a private space with a lockable door, a safe and barrier-free environment, 24 hour monitoring and emergency response, and an option for meals. The housing may be self-contained or shared, owned or rented. Supportive housing can be built or developed by making existing homes and neighborhoods more supportive to meet the needs of individual clients.

In addition, some sites coordinate the delivery of home care, physician and pharmacy services. The services can range from a "light end" supportive housing model to a "high end" supportive housing model. Most often, the "high end" of supportive living is typically viewed as assisted living while the "low end" is viewed as supportive housing. The emphasis in supportive housing is on the residents' independence, balanced with their need for a sense of community, around the clock security, daily assistance with every day chores such as shopping, and opportunities for social interaction with others.

Assisted Living

The term "assisted living" describes an approach or philosophy of care that is provided in an environment or setting that differs from the traditional nursing home. It is a residential long term care alternative that involves the managed delivery of uniquely prescribed health and personal services within a residential environment. Assisted living is rooted in residential housing and hotel services as opposed to a hospital type building and the medical model of care.

There are twelve principles for the design and practice of an assisted living model for frail, older adults. These principles are:

- Privacy
- Social interaction
- Control/choice/autonomy
- Orientation/wayfinding
- Safety/security
- Accessibility and functioning
- Stimulation/challenge
- Sensory aspects
- Familiarity
- Aesthetics/appearance
- Personalization
- Adaptability principles

For the purpose of this report, "assisted living" is defined as settings where together, the operator and the clients share the risk of care delivery. Usually these shared risks are negotiated between the operators and the clients/families on an individual basis and become tailor made to meet the individual's needs and choices in maintaining independence.

Lodges

Lodge settings provide room and board services for seniors who are functionally independent. This is a public housing program established by Alberta Municipal Affairs that offers affordable accommodation to senior citizens.

Enhanced Lodges

An "enhanced lodge" is a new concept that describes a new generation of lodges. These enhanced lodges provide services beyond those currently provided in traditional lodges. These new services may include but are not limited to personal care, medication support and contracted home care services based on assessed needs of the residents, as well as light housekeeping and other services may be provided. Some enhanced lodges have developed specialized areas in the facility to provide services for persons with Alzheimer's/ dementia.

Components of Continuing Care Services

Clinical and Therapeutic (Professional) Services

There are two components to clinical and therapeutic services. One component is assessment and coordinated services and the second component is professional services. Assessment and coordinated services include assessment, service planning and ongoing joint service coordination between the provider and client and/or family. These services are provided as part of the "coordinated access" process. Professional services are usually, but not exclusively, provided by health professionals such as registered nurses, physicians and therapists in accordance with professional legislation and also include formal delegation and supervision of care of specific tasks to para-professionals and support workers. This definition only includes services authorized and/or funded by regional health authorities. Professional services can be delivered in a variety of sites, including continuing care centres, supportive housing sites and "private dwellings" of individuals.

Assistance to Daily Living Services

Assistance to daily living services enables individuals to function as independently as possible by supporting them and their families in the management of their health care. These services include basic activities of daily living (grooming, bathing, feeding, etc.) and instrumental activities of daily living (laundry, housekeeping, meal preparation, etc.)

Coordination and Linkage to Social Support and Other Services

Clients need a mechanism that coordinates and provides a linkage to services outside the mandate of the health authorities. These services provide a social support network for clients. The health authorities provide a leadership role by coordinating community mobilization of these services. The services may include accompanying clients while shopping and/or to medical appointments, providing opportunities for social interactions such as social functions and a variety of other services.

Primary Health Care

Primary health care is health care that is provided at the first level of contact with the health system, where people first enter the health system. Services are mobilized and coordinated, usually by an interdisciplinary team, to promote health, prevent illness, care for common illness and manage health problems. Primary health care workers can be a variety of health care professionals such as physicians, nurses, therapists, and social workers. Usually a team of health care professionals coordinates these services.

Primary Medical Care

Primary medical care is medical care provided by physicians to their clients. The family physician is the coordinator of primary medical care.

Appendix 3

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